Roadmap to Cost Containment

Massachusetts Health Care Quality and Cost Council Final Report

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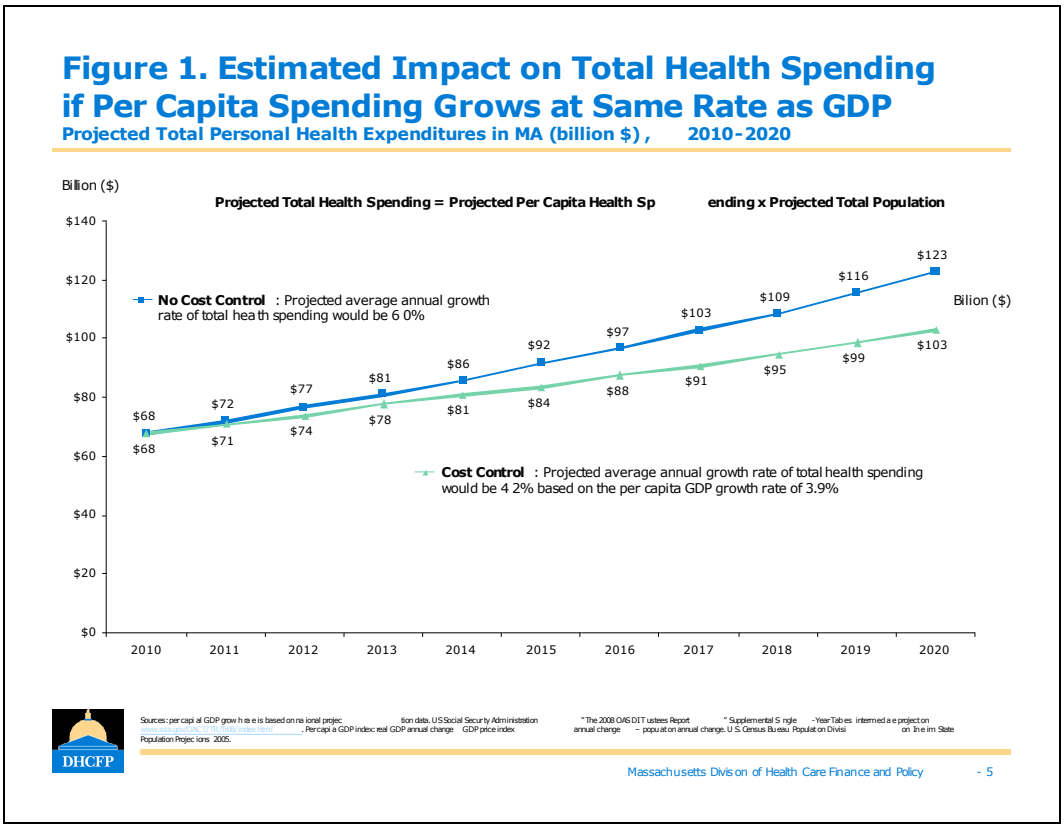
Introduction

Health care cost increases in Massachusetts and the nation are unsustainable. Rates of increase far outpace growth in the economy, threaten the financial health of individuals and businesses, and squeeze out other priorities for government spending. This is a national problem, but Massachusetts must identify and implement policies and actions at the state level to address what many describe as a crisis now. Left unchecked, health care costs in Massachusetts are expected to rise by an average of six percent annually during the period 2010-2020,[1] while GDP is projected to grow at less than four percent (see figure 1 below). It is therefore imperative that we undertake meaningful health care cost control efforts in the Commonwealth. At the same time, Massachusetts has a high-quality health care system. Effective cost control need not compromise that quality and should, if done right, enhance it.

Figure 1



[1] It should be noted that this is an estimate of the average rate of growth in costs across all payers, public and private. It is expected that actual rates of increase for private payers will be significantly higher than six percent, while increases for public payers (Medicare and Medicaid) will be significantly lower.

As in our efforts to expand health insurance coverage, effective cost control will require a shared responsibility by all who deliver, use and pay for care. Health care providers must take on the central work required to control health care costs while maintaining or improving quality as they redesign their organizations and processes of care to be more efficient and deliver better value. However, to be successful and have the maximum impact on cost and quality, we must create a system that supports, encourages, rewards and augments health care system redesign and population health management through the shared efforts and commitment of payers, consumers, employers and government. This effort is not aimed at cost shifting from one constituency to another—it is aimed at sustainable cost control, the benefits of which accrue to all of us.

To realize this vision, the Health Care Quality and Cost Council (HCQCC) puts forth the following Roadmap to Cost Containment. The Roadmap contains discreet strategies that HCQCC believes, if implemented strategically, will allow the Commonwealth to meet its goal of sustainably containing cost growth in health care. These strategies are remarkably consistent with the quality agenda of HCQCC.

Specifically, HCQCC recommends:

- Comprehensive payment reform
- Support of system-wide redesign efforts
- Widespread adoption and use of health information technology (HIT)
- Implementation of evidence-based health insurance coverage informed by comparative effectiveness research (CER)
- Implementation of additional health insurance plan design innovations to promote high-value care
- Development of health resource planning capabilities
- Enactment of malpractice reform and peer review statutes
- Implementation of administrative simplification measures
- Consumer engagement efforts
- Emphasis on the prevention of illness and the promotion of good health
- Increased transparency

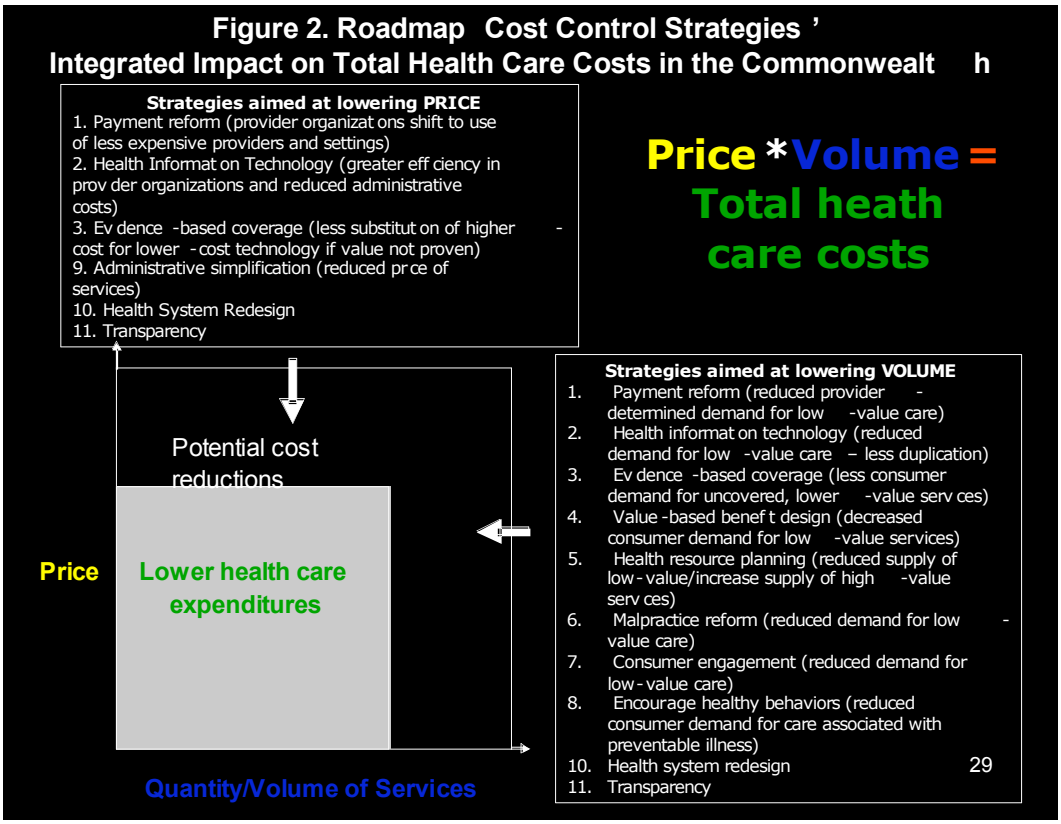
Each of these strategies has been shown to be effective in reducing health care costs, or cost growth, on a limited basis. Small-scale examples exist in Massachusetts and in other states. Here we are recommending full-scale, integrated implementation of the combined strategies for maximum impact in the Commonwealth and to address the crisis we currently face.

A number of the strategies are underway. Current system-wide efforts exist to adopt and use HIT, simplify administrative processes and increase transparency. Each of these current efforts will be monitored closely by HCQCC as part of its enhanced monitoring efforts. In addition, significant work is being done to engage consumers through the implementation of a multi-payer medical home model and the Department of Public Health is working diligently to implement strategies that promote good health and prevent chronic illness. The remaining strategies require planning and implementation.

Health care spending is a product of the price of health care services and the amount we use. Use is affected by both consumers and providers. The strategies proposed here are intended to reduce

care that is unnecessary, duplicative, and of no or marginal benefit as well as to reduce the price we pay for that care over time, thereby increasing the efficiency of our health care system and reducing the rate of cost growth. It has been estimated that 20-30 percent of acute and chronic care provided in the United States is not clinically necessary.[2] The strategies we propose are aimed first and foremost at reducing the amount of such "low-value" care we provide and pay for, and are not intended in any way to result in reductions in or withholding of necessary health care. Figure 2 illustrates how we see these strategies affecting overall costs.

Figure 2



The Roadmap Strategies

The Roadmap includes eleven complementary strategies that range from activities where work is underway and the strategies that can be implemented in the short term to longer-term strategies that will take significant time to implement.

[2] Becher EC and Chassin MR. "Improving The Quality of Health Care: Who Will Lead?," *Health Affairs*, 20(5), 164-179, 2001.

Shorter-Term Strategies

There is an imperative to contain costs now. There is significant ongoing work in the Commonwealth to both improve quality and contain health care costs. A number of those efforts have the potential to impact the health care growth trend in the short term, including:

Administrative Simplification

Most health care spending pays for the direct provision of care. However, administrative costs, in terms of both costs incurred by insurers to administer coverage and costs incurred by providers and patients in navigating the system and complying with rules, are significant.[3] Chapter 305 of the Acts of 2008 included a number of efforts to reduce administrative complexity in health care, including the Division of Insurance's (DOI's) effort related to uniform billing requirements by payers. Further, a number of significant voluntary efforts are underway such as the Patrick administration's Healthy Mass Compact and efforts of the Employer's Action Coalition for Health (EACH) to reduce administrative costs related to eligibility verification for both commercial and public payers. HCQCC commends the work to date to reduce administrative burdens within the health care system and recognizes that it is difficult to make progress and remain committed to these projects given the limited state resources. Despite limited state resources, a continued focus on efforts to reduce administrative complexity is imperative. This work demonstrates the state's commitment to do its part to reduce health care costs in the Commonwealth by easing regulatory burdens on payers and providers wherever possible, and has the potential to remove significant costs from the system.

Consumer Engagement Efforts

HCQCC recommends a multi-faceted campaign to increase consumer engagement in health care through increased awareness of the health care system and specific treatment options for their individual care. Specifically, HCQCC recommends leveraging the work of organizations such as the Partnership for Healthcare Excellence, which are continuing to embark on public education campaigns and on-the-ground outreach in target markets, with documented success. To complement these public education campaigns, HCQCC urges additional consumer engagement, through models such as Shared Decision-Making and the Patient-Centered Medical Home, which have been shown effective as a means of shifting consumer demand from low-value to high-value care and improving quality by better reflecting patient preferences for care.[4] Such consumer engagement is a critical underpinning of a redesigned health care system.

The Executive Office of Health and Human Services (EOHHS) is facilitating a Patient-Centered Medical Home Initiative (PCMHI). The PCMHI effort involves all of the major private payers,

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[3] According to a September 2008 report commissioned by the Massachusetts Division of Insurance, insurers utilize 10.9% of each premium dollar for administrative expenses (excluding investment expenses). See "Analysis of Administrative Expenses for Health Insurance Companies in Massachusetts, Massachusetts Division of Insurance, prepared by Oliver Wyman, September 2008.

[4] See Annette M. O'Connor, John E. Wennberg, France Legare, Hilary A. Llewellyn-Thomas, Benjamin W. Moulton, Karen R. Sepucha, Andrea G. Sodano, and Jaime S. King. "Toward The 'Tipping Point': Decision Aids And Informed Patient Choice." *Health Affairs*, May/June 2007; 26(3): 716-725. See also, John E. Wennberg, Annette M. O'Connor, E. Dale Collins, and James N. Weinstein. "Extending The P4P Agenda, Part 1: How Medicare Can Improve Patient Decision Making And Reduce Unnecessary Care," *Health Affairs*, November/December 2007; 26(6): 1564-1574.

MassHealth and other public payers, representatives of the primary care community, purchasers, consumer advocates, and researchers. Beginning in June 2009, an advisory council consisting of over 50 individuals began an intensive planning process with a goal of implementation during 2010.

Promoting Good Health

The medical care costs of people with chronic diseases account for more than 75 percent of the nation's medical care costs.[5] Many chronic diseases arise and worsen because of a variety of factors, including environmental conditions, socio-economic factors, and behaviors of the individuals afflicted. These factors account for at least 900,000 deaths annually in the United States About half of these are related to diet or physical activity, and the other half are primarily due to decisions regarding tobacco use. Of these 900,000 deaths, about 40 percent are "early deaths," that is, they occur at younger ages than would normally be expected. Taken together, the complex factors that result in unhealthy behaviors represent the single greatest domain of influence on the health of the population.[6]

In Massachusetts, while we have made great strides in reducing rates of smoking, trends are not as positive in other areas.[7] Obesity incidence almost doubled in Massachusetts between 1995 and 2008, growing from 11.7 to 22.5 percent of the population. Parallel to the increased prevalence of obesity has been growth in the prevalence of diabetes. Diabetes in the Massachusetts population grew 29 percent in a recent four-year period.

HCQCC endorses a multi-part strategy to promote increases in healthy behaviors across the state population in order to reduce incidence and growth in severity of the chronic conditions that account for most health care spending in the Commonwealth. This effort should be spearheaded by the Department of Public Health, but shaped and implemented by a broad array of entities. Its component elements should be:

#1: Community Engagement

As part of its *Mass In Motion* program to prevent obesity and to reduce chronic disease, DPH initiated a community grant program and created a website (www.mass.gov/massinmotion/) to provide tools to communities to implement activities such as:[8]

- Changing school food service requirements;
- Changing school curricula;
- Providing after-school programs;
- Reaching out to parents, city employees, and communities;
- Working with restaurants to increase healthy menu options;
- Developing "walkability" and safe routes to school;

[5] Chronic Disease Overview, Centers for Disease Control and Prevention, www.cdc.gov/nccdphp/overview htm, accessed August 4, 2009.
[6] McGinnis JM et. al., "The Case For More Active Attention to Health Promotion," *Health Affairs*, 21(2), 78-93, March/April 2002.
[7] apps nccd.cdc.gov/brfss/display.asp?cat=TU&yr=2008&qkey=4396&state=MA, accessed August 4, 2009.
[8] www.somervillema.gov/Division.cfm?orgunit=SUS, accessed August 4, 2009.

- Working with school nurses and pediatricians; and
- Developing farmers markets and community/school gardens.

HCQCC recommends that DPH coordinate and, when possible, expand the funding for and scope of such efforts in additional Massachusetts communities.

#2: Employer Engagement

According to the National Compensation Survey, approximately 28 percent of United States private sector workers had access to employer-sponsored wellness programs in 2008.[9] HCQCC commends DPH for its workplace wellness initiative. It recommends that it strengthen such efforts by collaborating with employer organizations in the Commonwealth to increase the prevalence of such programs, in a manner that involves health insurers.

#3: Evidence-Based Regulatory Interventions

Public health regulation can make a big impact on healthy behaviors. HCQCC supports DPH's use of evidence-based interventions, such as nutritional menu labeling and school-based body mass index (BMI) measurement, which can contribute to healthy behaviors. HCQCC encourages DPH to consider and propose additional and bold strategies.[10]

#4: Public Health Campaigns

Recognizing the success of previous public health campaigns, HCQCC urges restarting and maintaining such campaigns, to keep the messages at the forefront. Among the topics to address should be preventing or reducing smoking, substance abuse, poor eating habits, and lack of physical activity. Such campaigns should target children and adolescents as well as other populations at risk.

Promoting Transparency

There are significant efforts well underway in the Commonwealth that promote transparency of data and analysis on health care quality and costs. HCQCC, since its inception, has been charged with collecting and making quality and cost data more available to consumers as well as to the health care community. Currently, HCQCC receives data from all of the major Massachusetts health plans and develops measures through this "fully-insured" data set. In addition to the efforts of HCQCC, a number of state agencies, including the Division of Health Care Finance and Policy (DHCFP), the Department of Public Health (DPH), and the Division of Insurance (DOI) collect and report on various aspects of health care quality and costs. DHCFP collects data from all payers and utilizes its "all payer" database to produce a variety of data on health care spending and trends. Chapter 305 of the Acts of 2008 expanded the efforts of DHCFP to include, among other things, collection of comprehensive data from public and private payers and to annually hold a public hearing focused on provider and cost trends. The Attorney General was also granted authority to participate in such hearings.

[9] www.bls.gov/opub/cwc/cm20090416ar01p1 htm, accessed August 4, 2009.

[10] For example, the Public Health Council has previously endorsed a tax on sugar-sweetened drinks. Likewise, the Commonwealth Fund has advocated the creation of such a tax and modeled savings that would result from such a strategy. See "Bending the Curve," The Commonwealth Fund Commission on a High Performance Health System, December 2007.

HCQCC believes that while these current efforts are a good start with respect to transparency in the delivery system, there is still more to be done both through continued HCQCC efforts to add to its database and reporting capabilities. In addition, as a step towards greater transparency in the payer system, HCQCC supports the Patrick administration's recently announced efforts to expand DOI's current review of insurance premiums and its authority. DOI will soon hold hearings to examine small business premium increases; the hearings will focus on efforts to reduce costs, and future steps that may be needed to eliminate the substantial increases impacting the small group market. The Patrick administration also plans to file legislation that will amend small-group rating rules, giving DOI expanded power to annually eliminate unnecessary administrative costs and align factors in ways that could reduce the premiums charged to most small businesses. It also plans to file legislation that will expand DOI's authority over health insurance premiums to allow for prospective rate review and disapproval of rates deemed unreasonable in relation to the benefits provided. As DOI increases its review of health insurance premiums, HCQCC recommends that DOI develop standard measures of transparency to allow for true comparison across the plans.

Longer-Term Strategies

To recognize long-term sustainable cost containment, a major redesign of how health care is delivered and paid for is essential. In addition, there are a number of supportive efforts that will assist the Commonwealth in realizing a high-quality, efficient health care system. The longer-term strategies include:

Comprehensive Payment Reform

HCQCC believes that payment reform is central to controlling health care costs in Massachusetts. The current system of payments for health care services is dominated by fee-for-service, which is inherently inflationary, rewards overuse of health care services, does not reward primary care, preventive care, or care coordination, and contributes to administrative complexity.

The greatest potential for reducing the long-term health care cost trend in Massachusetts lies in changes in the composition and use of health care resources. The best way to achieve these savings is to develop a payment system that encourages and reinforces fundamental cultural and structural changes in our delivery system, such as:

- Greater investments in primary care capacity;
- Promotion of the right care in the right place;
- Greater attention to prevention and wellness;
- Better management of chronic disease;
- Better integration of behavioral health care;
- Better coordination of care across care settings; and
- Capital investments and technology diffusion based on need, evidence, and quality.

HCQCC believes global payment models have the potential to provide incentives for efficiency in the delivery of services that are missing in the fee-for-service system, while potentially driving improvements in quality through better coordination of care. However, transition to global payments will take time, and there is an urgent need for control of health care cost growth.

We therefore recommend four components of payment reform:

1. Public and private payers should immediately increase use of payment methodologies that will support health care delivery system redesign, including:

    - increased use and alignment of pay-for-performance across payers and providers;
    - implementation of bundled or episode-based payments;
    - support for patient-centered medical homes; and
    - reduced payments for avoidable hospitalizations and preventable readmissions.

2. The state should encourage global payments as a major model for health care payments in Massachusetts. As suggested by the Special Commission on the Health Care Payment System, a Board should be established to guide and monitor the implementation of global payments. The implementation plan and timeline should recognize the complexities and address specific outstanding issues and challenges of global payments. The legislation should provide clear guidance to the Board as to the principles for its decision-making. Global payments should result in cost savings to both payers (employers, government) and consumers. Specifically, HCQCC recommends that the following issues must be addressed:

    a. Set parameters for the size of accountable care organizations (ACOs) to avoid over aggregation that could skew market power while allowing aggregation to create integrated systems;
    b. Provide clear guidance and support for integrated provider organizations, including a clear definition of ACOs and a licensing or certification process for ACOs;
    c. Emphasize and incentivize system redesign that emphasizes preventive and primary care, increased use of nurse practitioners and physician's assistants, where appropriate; improved integration of care and care coordination, and improved access and quality, with the substitution of less expensive care where quality is not compromised;
    d. Develop a standard global payment methodology, which includes a standard risk-adjustment methodology;
    e. Balance maintenance of appropriate patient choice with goals of providing high-quality health care in the most efficient manner;
    f. Resolve anti-trust and other legal and regulatory issues that may impede implementation of payment reform, and
    g. Identify default interventions such as utilizing rate setting if sufficient progress in controlling costs is not made.

3. HCQCC should set cost control targets and monitor cost growth and DHCFP should explore government options for rate regulation if cost control targets are not met. In case there is limited progress toward global payments or set targets are not met, HCQCC will request that DHCFP report back in no more than six months from the date of HCQCC's request regarding progress toward cost control goals and the potential impact of rate regulation in meeting these goals more rapidly.

4. Consistent with key proposals in pending federal legislation, the state should continue efforts to work with the Centers for Medicare & Medicaid Services (CMS) on alternative payment models and system redesign initiatives, including implementation of medical homes and efforts to coordinate incentives for coordinated, efficient care for Massachusetts residents that are dually eligible for Medicare and Medicaid. Further, the state should work with CMS to utilize its Center for Innovation to include Medicare's participation in payment reform efforts in Massachusetts.

Ideally, implementation of payment reform should:

- Occur on a statewide basis;
- Be implemented across all public and private payers;
- Provide for an appropriate transition period;
- Include technical and other support for providers; and
- Have as a goal reducing cost-shifting between public and private payments.

HCQCC places particular emphasis on the promise that payment reform will create incentives for providers to better coordinate care on behalf of their patients across care settings. In a redesigned health care system, HCQCC believes that quality of care provided to patients will improve and that unnecessary emergency room visits, preventable hospital admissions, and hospital readmissions will be reduced. System-wide use of interoperable health information technology (HIT) is necessary to fully realize this transformation in care delivery.

HCQCC also believes that it is essential to identify and track system-wide cost and quality measures that will allow the state to both gauge the effects of payment reform and ensure that providers are held accountable for providing high-quality care. HCQCC's recommendations for quality and cost monitoring are described below.

Widespread Adoption and Use of Health Information Technology

HIT is necessary infrastructure to improve the quality of care provided to patients and improve efficiency through better coordination of care among multiple providers, providing patients with electronic access to their provider and their own health information, and making information more readily available for population health management purposes. HIT, if it is designed with the explicit goal of supporting system redesign, has the potential to reduce unnecessary and duplicative testing, reduce the administrative burden on providers, and improve clinical quality.[11] Significant work is underway. The Massachusetts eHealth Institute (MeHI) and the HIT Council are charged, through Chapter 305 of the Acts of 2008, with ensuring that all providers have and utilize electronic health records (EHRs) and interoperable networks by January 1, 2015.

In addition, the federal government, as a result of the American Reconciliation and Recovery Act (ARRA) of 2009, is funding efforts to support the adoption of meaningful use of interoperable EHRs and to develop the capacity for widespread health information exchange. These efforts will also be coordination by MeHI and the HIT Council.

[11] "Evidence on the Costs and Benefits of Health Information Technology," The Congressional Budget Office, May 2008.

HCQCC will closely monitor progress towards this goal as part of its Roadmap and assess the need for any additional intervention.

Implementation of Evidence-Based Health Insurance Coverage Informed by Comparative Effectiveness Research

HCQCC has identified overuse of health care services, or low-value care, as a significant factor in health care cost growth.[12] Furthermore, overuse can result in harm to patients and their families. Comparative effectiveness research (CER), which provides information on the relative strengths and weakness of medical interventions to support provider and patient decision-making, has been used successfully to reduce unnecessary care.[13] CER is used to evaluate whether the research evidence demonstrates clinical effectiveness of a specific treatment or intervention for a defined population(s). CER also considers the comparative clinical and cost effectiveness of the service relative to other service alternatives.

HCQCC believes that available comparative effectiveness information and analysis should be utilized to develop consensus recommendations for coverage and medical necessity policies in Massachusetts that could be implemented across private and public payers. HCQCC, therefore, recommends the creation of an entity governed by a board consisting of providers, consumers, payers, employers, and clinical experts. The entity could be state-based, or part of a regional collaborative as is being considered pursuant to Chapter 305 of the Acts of 2008.

The entity would not conduct effectiveness studies, but would leverage existing efforts currently used by the Commonwealth's payers and would directly or through contract synthesize existing CER findings. It would disseminate these syntheses to insurers, employers, providers, and consumers. In addition, it would develop or identify tools or resources to assist in the implementation of its findings and recommendations, including how to address individual patient cases and circumstances.

The entity would focus its efforts on those services for which the highest levels of overuse are suspected, with specific attention to services for which overuse is resulting in significant patient harm, and/or high expenditures. This strategy would create consistency in medical policy across payers, which would reduce the administrative burden on providers and administrative costs to payers. As appropriate, the entity may focus on dissemination about underuse of services where it impacts the public health.

DHCFP and DOI should convene the participants in this effort for initial discussion and develop an action plan.

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[12] See, e.g., "An Agenda for Change, Improving Quality and Curbing Health Care Spending: Opportunities for Congress and the Obama Administration," A Dartmouth Atlas White Paper, Dartmouth Institute for Health Policy and Clinical Practice, December 2008.

[13] For example, hormone replacement therapy (HRT) in women was a popular treatment for menopause in the 1990s, prior to a large-scale clinical trial which showed that HRT imposed health risks that exceeded its benefits. Following the study, usage of HRT declined by 43%. See MedPAC. Report to Congress: Reforming the delivery system. Washington, DC: MedPAC; June 2008.

Implementation of Additional Health Plan Design Innovations *to Promote High-Value Care*

Some employers have shown significant cost reductions by introducing financial incentives and supportive outreach programs that promote employee health. These programs usually provide incentives for at-risk or high-cost populations of employees to use services that are proven to be of "high value" and are aimed at improving health and reducing costs. Programs also have used financial incentives to encourage the use of more efficient and higher-performing providers. Despite the success of these programs, so-called value-based benefit design has not diffused throughout the Massachusetts market.

HCQCC recommends that DOI, jointly with the Executive Office of Health and Human Services (EOHHS) and Massachusetts employer and consumer representatives, convene a standing committee charged with developing and deploying throughout the marketplace innovative insurance products, which utilize value-based benefit design principles. The standing committee should promote existing and develop new products that provide meaningful incentives to consumers, which will lead to improved health outcomes and reduced premium cost. The standing committee should also identify barriers and strategies to reduce barriers to the promotion of new products, including flexibility in network adequacy requirements and opportunities to allow for more expeditious review of plan submissions by the DOI.

Development of Health Resource Planning Capabilities

HCQCC has identified oversupply of health care services in Massachusetts as a driver of the overuse of health care services.[14] Overuse, in turn, has been identified as a significant factor in health care cost growth. We also are heavily-reliant on hospital-based care, and lack an adequate supply of primary care providers. The payment reform strategies endorsed within this Roadmap are designed, in part, to specifically address these problems. However, HCQCC also recommends that EOHHS, through DHCFP and DPH, enhance its current analysis of health resources with required regular statewide assessments of the Commonwealth's health resource needs and informed recommendations related to planning, assessing and allocating health care services based on the needs of Massachusetts residents.[15] Health planning efforts should specifically monitor and analyze the impact of the development of ACOs on availability of health resources in the Commonwealth.

Having this enhanced responsibility within DHCFP and DPH will allow for leveraging existing data and expertise. Additionally, it will allow EOHHS to leverage current resources in DHCFP and DPH to efficiently incorporate these activities. In addition, EOHHS will be in a strong position to quickly see potential unintended consequences of the Commonwealth's efforts towards global payments.

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[14] Supply-sensitive care is care in which there is unwarranted variation in frequency of use that typically is explained by supply. That is, where there is greater capacity for particular care or services, more of that care or services are supplied. According to the Dartmouth Atlas, supply-sensitive services include physician visits, diagnostic tests, hospitalizations and admissions to intensive care among patients with chronic illnesses. See *Supply-Sensitive Care*, A Dartmouth Atlas Project Topic Brief, Center for Evaluative Clinical Services, January 15, 2007.

[15] The Office of Health Resource Planning would merge some current state responsibilities that sit within the Division of Health Care Finance and Policy (including analysis and assessment of health care service availability and cost) and the Department of Public Health (including Determination of Need).

HCQCC envisions the following enhanced responsibilities: (1) health planning activities, including a conducting a comprehensive regular assessment of current and future health care service availability and need, and (2) enhanced Determination of Need (DoN) activities through increased use of data identified in the health resource planning process and increased regulatory oversight of proposed projects.

Enactment of Medical Liability Reform

The practice of defensive medicine, whereby doctors provide unnecessary or low-value service out of fear of legal liability, is another source of overuse in the health care system.[16] According to a recent report by the Massachusetts Medical Society, the practice of defensive medicine costs $1.4 billion per year in the Commonwealth.[17] In addition, the Congressional Budget Office (CBO) just released a revised estimate of savings that can be expected through malpractice reform that supports the notion that malpractice reform will have a significant impact on reducing the practice of defensive medicine.[18] HCQCC believes that an important element of a redesigned health system is providing appropriate protections to providers to help reduce the practice of defensive medicine. We therefore recommend that the state legislature enact appropriate malpractice reform that will help lessen this phenomenon.

Peer review, through which providers compare their work for both unwarranted variations in practice and potential sources of error or waste, also has proven effective in reducing overuse of health care services.[19] HCQCC therefore recommends adoption by the state legislature of a peer review statute that would allow for greater information-sharing between providers, regardless of where they work, to promote lessons learned and best practices without the fear that the results of such learning could be used against them in a malpractice case.

Widespread Adoption of the Sciences of System Design and Engineering By Health Care Providers

In order to successfully implement this Roadmap, significant system redesigned focused on both process and infrastructure improvements is necessary. These changes will impact the way many providers practice medicine today. System redesign needs to be embraced both by individual providers and organizations as well as across the health care community and its stakeholders.

This system redesign will require significant support to ensure that it is incorporated into every day practice and truly improves the quality of health care provided. HCQCC recommends that EOHHS take a leadership role to bring the health care community together with large employers

[16] Investigation of Defensive Medicine in Massachusetts," Massachusetts Medical Society, November, 2008. There have been a number of surveys of physicians in other states that also suggest a strong link between fear of malpractice and the practice of defensive medicine. See, for example, Studdert, David M. et al.; Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment, *Journal of the American Medical Association*, June 2005, Vol. 293, pages 2609-2617; which conducted a study of physicians in Pennsylvania.
[17] "Investigation of Defensive Medicine in Massachusetts," Massachusetts Medical Society, November, 2008, Waltham, MA.
[18] October 9, 2009 Letter from CBO Director Douglas Elmendorf to Senator Orrin Hatch; accessed at www.cbo.gov on October 13, 2009.
[19] See, e.g., Ineke Welschen, Marijke M Kuyvenhoven, Arno W Hoes, and Theo J M Verheij, Effectiveness of a multiple intervention to reduce antibiotic prescribing for respiratory tract symptoms in primary care: randomised controlled trial, BMJ, Aug 2004; 329: 431.

and the Commonwealth's colleges and universities to form public/private partnerships and coordinate the continue development of expertise among employers, providers, state agencies, and educational institutions to support health care system redesign.

EOHHS and its collaborators should convene periodic educational forums that allow stakeholders to learn and share experience from system redesign efforts. Forums will showcase elements of the sciences of system redesign, including both process and infrastructure improvements, and presenters should be both from Massachusetts and across the country. In addition to the educational forums, EOHHS should work with willing stakeholders, including large employers and universities, to also support research projects, cross industry partnerships, improvement collaboratives, and other shared projects that will reinforce the other recommended strategies to redesign the health care system and contain unnecessary costs.

Potential for Reducing Health Care Costs

Taken together, the eleven strategies included within this Roadmap will put the Commonwealth on course to meet our cost containment goals. RAND Corporation (RAND), in a study commissioned earlier this year by DHCFP, estimated spending on health care in Massachusetts in 2010 at $43 billion, and cumulative spending between 2010 and 2020 at $670 billion.[20] The strategies recommended in this Roadmap provide tools to shift the spending curve by creating a more efficient health care base, while also reducing the rate of cost growth over time.

As detailed in RAND's report analyzing potential strategies, it is difficult to precisely estimate health care cost savings.[21] There is limited empirical evidence or literature that provides solid evidence that the proposed cost containment strategies will, in fact, save dollars in the long run. In nearly half of the strategies that RAND undertook to review, RAND determined that they would not be able to accurately model any savings.[22]

Of the eleven strategies ultimately included in the Roadmap, RAND modeled three. In each of these cases, RAND modeled the potential savings without the inclusion of Medicare. We are advocating the inclusion of Medicare in cost control efforts, and therefore expect that potential savings could be much larger than RAND predicted. RAND's estimates include:

> **Health Information Technology Adoption**: RAND found that increased adoption of HIT had a savings range of a potential increase of $3.7 billion to a decrease of $12.1 billion over ten years.
>
> **Value-Based Insurance Design**: RAND found that implementation of value-based insurance design had a savings range of a potential increase of $1.1 billion to a decrease of $1.2 billion over ten years.

Independent estimates of the effect of global payments on health care spending are not available. There are almost no experimental or quasi-experimental studies with capitation in the United

[20] "Controlling Health Care Spending in Massachusetts: An Analysis of Options," August, 2009, RAND Health.
[21] RAND, page 4.
[22] RAND, p. 39.

States,[23] let alone with more comprehensive notions of global payments. Where research has been performed using other methods, it generally has shown that risk-sharing with providers reduced utilization and costs relative to fee-for-service payment. Most of this research was performed studying the capitation arrangements in use in the late 1980s and early 1990s.[24] Moreover, this research was performed at a time when there was significant excess hospital bed capacity in the United States, much of which has since been removed.

RAND modeled a number of cost control interventions that likely would occur as a result of payment reform. HCQCC believes that these strategies will be undertaken by providers in preparation for or as a result of payment reform and are create a reasonable expectation that total savings will exceed the amount estimated for bundled payments. These include:

- Create medical homes to enhance primary care, with a savings range of a potential increase of $2.8 billion to a decrease of $5.7 billion over ten years.
- Encourage greater use of nurse practitioners and physician assistants, with a savings range of $4.2 billion to $8.4 billion over ten years
- Eliminate payment for adverse hospital events; with a savings range of $7.6 billion to $12.3 billion over ten years.[25]
- Implement bundled payment strategies; with a savings potential between $685 million and $39 billion over the next ten years.[26]

Measuring, Monitoring and Mid-Course Corrections

HCQCC must take an active role in monitoring the progress of the Commonwealth toward containing health care costs and improving quality. To that end, HCQCC will develop a scorecard for public release no less than annually. The scorecard will allow policymakers a high-level view of the aggregate success of the cost containment strategies recommended within this Roadmap. It will serve as an indicator of whether strategies are progressing as intended, or there is a need for closer monitoring and potential course-correction for a particular strategy. Monitoring shall include, at a minimum, aggregate measures of cost, quality, and efficiency such as:

- Reduction in emergency room usage
- Reduction in hospital readmission rates
- Reduction in preventable hospitalizations
- Reduction in hospital-acquired infections
- Reduction in serious reportable events
- Reduction in per person end-of-life spending
- Reduction in growth of Medicaid spending on nursing facility services
- Increase in amount of provider payments being made as global payments
- Increase in provider rates of HIT usage

[23] Meredith Rosenthal, personal communication, July 10, 2009.
[24] Mathematica Policy Research. "Appendix C.2 Global Payment," from Recommendations of the Special Commission on the Health Care Payment System, July 16, 2009.
[25] Massachusetts payers and providers have already taken steps to reduce or eliminate payments for adverse hospital events.
[26] RAND, p. 13.

- Increase in consumer engagement[27]
- Decrease in per capita health care spending
- Decrease in annual growth in health insurance premiums
- Changes in out-of-pocket expenditures by health care consumers

The measures should be compared over time, and should also be compared to best practice states or providers, either within Massachusetts or elsewhere in the country. In addition, HCQCC encourages the development of more "patient-focused" measures which assess care across multiple settings and circumstances.

In addition to producing a scorecard, HCQCC will receive periodic updates on implementation progress for each of the nine strategies included within the Roadmap. Specifically, HCQCC will request that quarterly progress reports on each of the Roadmap strategies be submitted to the Cost Containment Committee by the appropriate entity (or entities).

The Full Report

In addition to this Roadmap Summary, HCQCC refers the reader to its Roadmap to Cost Containment, which provides more detailed information on each of the strategies, an implementation plan, and an inventory of ongoing related efforts in Massachusetts available at http://www.mass.gov/healthcare.

[27] There is no current accepted measure for this topic.

Chapter 1: Introduction

Background

Massachusetts had led the nation in efforts to enact and implement health care reform. When Massachusetts pursued universal health coverage with its landmark legislation in 2006, the entire health care community came together with a commitment to shared responsibility in expanding coverage. Now, three years into reform, with 97% of the Massachusetts population insured,[28] and health care costs growing at unsustainable rates, policymakers have urgently turned their attention to containing the rising costs of delivering health care services while the rest of the nation looks on. As in 2006, our efforts to contain rising costs must also be taken with a commitment to shared responsibility.

The Health Care Quality and Cost Council (HCQCC), created as part of the landmark health reform legislation in 2006, is charged by its operating statute to "establish statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care; and to demonstrate progress towards achieving those goals."[29] To meet its statutory mandate, HCQCC adopted a goal for the state to reduce the annual rise in health care costs to no more than the unadjusted growth in gross domestic product (GDP) by 2012.[30] In part, HCQCC is pursuing this goal through the development of the Roadmap to Cost Containment.

The Roadmap is a culmination of HCQCC's effort to delineate a path toward slowing the growth in health care spending by 2012. Beginning with the structure of HCQCC and the process for choosing the components of the Roadmap, the report examines the current trends in health care spending in the state and makes a set of comprehensive recommendations for how to contain costs while maintaining quality.

Project Organization

HCQCC engaged Bailit Health Purchasing, LLC (Bailit) in November 2008 to guide and coordinate the development of the Roadmap and created a Cost Containment Committee of HCQCC to oversee the development of the Roadmap to Cost Containment and consider a number of other cost-related issues before HCQCC. The Cost Containment Committee is made up of several members of HCQCC and is chaired by Sarah Iselin, Commissioner, Division of Health Care Finance and Policy, and Anya Rader Wallack, Executive Director, Massachusetts Medicaid Policy Institute.

As the Roadmap work got underway, HCQCC made a determination to leverage two ongoing projects in the Commonwealth. First, the Division of Health Care Finance and Policy (DHCFP) had previously engaged RAND to produce a report of the potential cost impact of a number of

[28] Massachusetts Division of Health Care Finance and Policy, "Health Care in Massachusetts: Key Indicators," May 2009.
[29] See Massachusetts General Law, Chapter 6A.
[30] Massachusetts Health Care Quality and Cost Council Annual Report, April 2008, http://www.mass.gov/Ihqcc/docs/annual_report.pdf

cost containment strategies based on an extensive discussion of potential strategies with stakeholders across Massachusetts. HCQCC determined that it would rely, to the extent possible, on the findings from the RAND report and that it would begin its discussion of potential strategies with the 21 strategies considered by RAND.[31]

Second, pursuant to Chapter 305 of the Acts of 2008, the Massachusetts legislature created the Special Commission on the Health Care Payment System (Special Commission) to examine the specific issue of how physicians and hospitals are paid for delivering services. As the Special Commission began its deliberations in January 2009, HCQCC decided it would leverage the work of the Special Commission for the Roadmap. The Special Commission issued a final report in July 2009. As will be discussed more completely in Chapter Five of this report, the Special Commission recommended that the Commonwealth move away from fee-for-service payments toward global payments, with adjustments for sicker patients. HCQCC concurs with this move towards global payments, while stressing the importance of implementing a fully integrated cost containment strategy that, as described in this Roadmap, is larger than payment reform.

Process

As a first step in the development of the Roadmap, HCQCC set out a number of principles and criteria for considering cost containment strategies.[32] Then, utilizing the 21 strategies being modeled by RAND, the Cost Containment Committee met on a monthly basis and began to review groupings of strategies and received a number of background papers on various cost containment strategies and the potential for the success of such strategies within Massachusetts.[33] The Cost Containment Committee also considered whether it should include additional strategies not being contemplated by RAND, including long-term care reform and better integration of physical and behavioral health. On the former, the Cost Containment Committee determined that since the vast majority of long-term care costs are borne through the state Medicaid program, which is currently involved in a process of developing a long-term care strategic plan that includes a focus on cost containment,[34] the Cost Containment Committee would not include specific long-term care recommendations within the Roadmap. Although the Roadmap does not include a specific strategy related to cost containment for long-term care spending, HCQCC will, as described in Chapter Six, monitor long-term spending as part of its overall monitoring of costs

[31] Appendix A provides a listing of the 21 strategies RAND reviewed as part of its work for the Commonwealth. RAND released its final report in August 2009 and its results are relied upon within this report. The complete RAND report is available on the Division of Health Care Finance and Policy's website at: http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_care_spending_rand_08-07-09.pdf

[32] The principles and criteria utilized by HCQCC are described in Chapter 3 and included as Appendix B to this report. financing mechanisms and public assistance while maximizing independence and assuring access to the necessary continuum of long-term care services.

[33] All background papers are available at Council's website: http://www.mass.gov/?pageID=hqccterminal&L=4&L0=Home&L1=The+Council&L2=About+the+Council&L3=Meeting+Schedule+and+Materials&sid=Ihqcc&b=terminalcontent&f=cost_containment_committee&csid=Ihqcc

[34] EOHHS convened a Long-Term Care Financing Advisory Committee, which has been meeting since January 2009, to identify strategic options for reforming the financing system for long-term care in a manner that supports a sustainable mix of personal and family responsibility, private financing mechanisms and public assistance while maximizing independence and assuring access to the necessary continuum of long-term care services.

and may recommend action in the future. On the latter, HCQCC believes that better integration of physical and behavioral health care is an essential aspect of the enhanced care coordination that is required to lower costs within the system, and that payment reform incentives should allow providers of these services to care for their patients in a more coordinated manner.

The Cost Containment Committee narrowed the strategies for inclusion in the Roadmap based on the principles and criteria. The group also considered the strategy's potential to contain costs while improving quality, current activity in the Commonwealth, and whether additional activity or monitoring around the strategy was warranted. Throughout the process, the Cost Containment Committee provided updates and obtained feedback from HCQCC's Advisory Committee and Bailit engaged a broad group of stakeholders to gauge support and elicit feedback on the strategies.

Chapter 2: The Case for Cost Control and Current Barriers

Problem Statement

With health reform paramount on the national agenda, not a day goes by where the media does not report on the unsustainable growth in health care spending in the United States or the urgency in which we must tackle the problem.[35] The United States has the highest health care expenditures per capita among industrialized countries. Current spending in the United States and in Massachusetts for health care services has been rising faster than the consumer price index, wages and salaries, and per capita gross domestic product.[36] As one of the most expensive states in the country in which to receive care, the issue of cost containment is even more urgent for Massachusetts. Some project that the increase in per capita health spending in Massachusetts will rise at a faster rate (6.5%) than the nation (5.8%) over the next decade.[37] Largely driven by these health cost increases, health insurance premiums have increased almost every year for the past two decades at a pace that well exceeds the annual increase in the cost of living. In its recent report on state health insurance premium trends, the Commonwealth Fund finds that family coverage through an employer in Massachusetts is the most expensive in the country at $13,788 annually.[38] However, as a percent of median family income, it is not the most expensive state. Some of the increased cost is due to a higher cost of living in Massachusetts. Data from DHCFP show that the average rate of increase in premiums in Massachusetts from 2001 to 2007 was 8.9% versus 7.7% nationally.[39]

Health care costs hurt individual citizens who are challenged to balance household budgets when wages are not increasing. Businesses struggle to compete when annual family health care premiums have begun to approach the wage level of a low-income employee, and displace wage growth for all. The fiscal year 2009 Massachusetts budget allocated just under $13 billion for health care, including Medicaid, Commonwealth Care (the state subsidized coverage for low-income individuals that are ineligible for Medicaid), and state employee and retiree health benefits.[40] In 2004, all health care spending made up 14.1% of the gross state product.[41] With spending on health care consuming a larger and larger portion of the commonwealth's budget,

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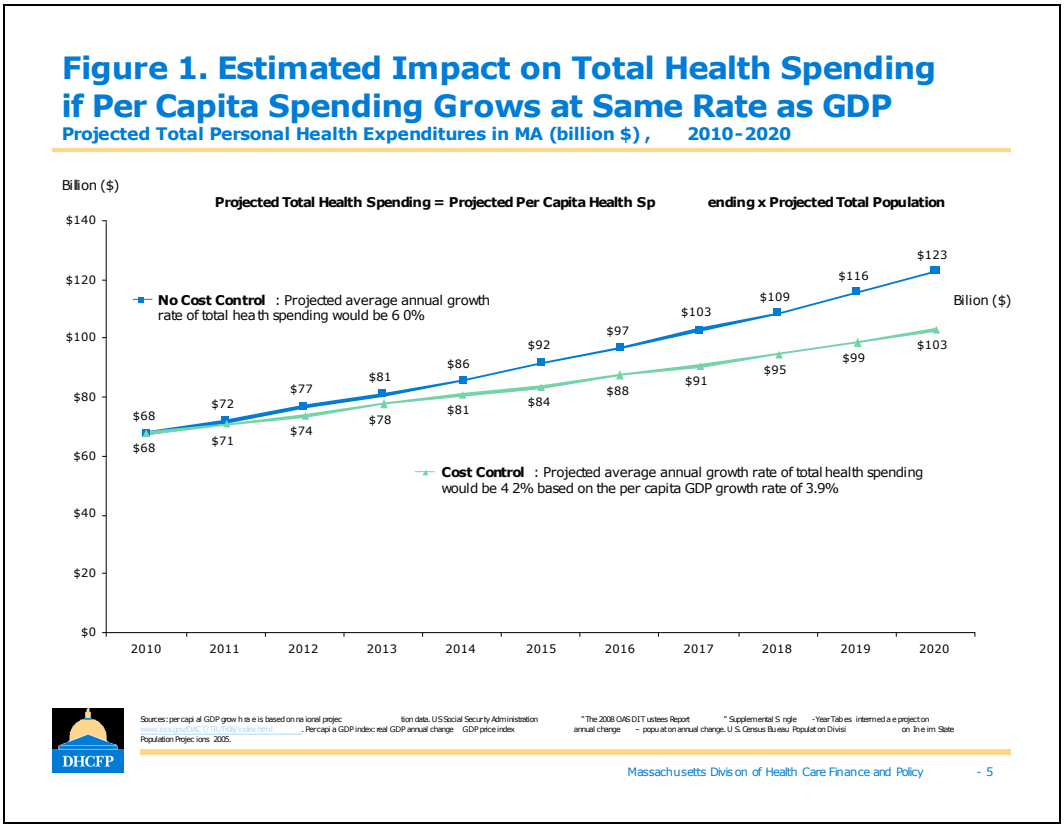
[35] Health care growth has been considered unsustainable for at least three decades and there have been numerous efforts to contain costs in the past.
[36] Massachusetts Division of Health Care Finance and Policy, "Massachusetts Health Care Spending Baseline Trends and Projections," February 4, 2009.
[37] Ibid.
[38] See C. Schoen, J. L. Nicholson, and S. D. Rustgi, Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes—State Health Insurance Premium Trends and the Potential of National Reform, The Commonwealth Fund, August 2009.
[39] Massachusetts Division of Health Care Finance and Policy, "Massachusetts Health Care Spending Baseline Trends and Projections," February 4, 2009.
[40] Massachusetts Budget and Policy Center, http://www.massbudget.org/documentsearch/findDocument?doc_id=673&dse_id=820
[41] Kaiser Family Foundation, State Health Facts, http://www.statehealthfacts kff.org/comparemaptable.jsp?ind=263&cat=5

efforts to reign in spending on state-funded programs are paramount. Moreover, health care spending continues to place significant pressure on employers and individuals alike.

Figure 1



As a nation and as a Commonwealth, we may not be as collectively concerned about spending greater portions of our available dollars on health care if those dollars were consistently buying high-quality care. However, that is not the case. It has been well documented that, despite our higher spending levels than other countries, the United States does not perform as well on quality measures as other industrialized nations.[42] Examples of unnecessary health care spending abound, particularly for potentially preventable emergency room visits and hospital admissions.[43]

[42] See, e.g., E. Nolte and C. M. McKee, Measuring the Health of Nations: Updating an Earlier Analysis, *Health Affairs*, January/February 2008, 27(1):58-71; K. Davis, C. Schoen, S.C. Schoenbaum, M. M. Doty, A. L. Holmgren, J.L. Kriss, and K.K. Shea, Mirror Mirror on the Wall: An International Update on the Comparative Performance of American Health Care, The Commonwealth Fund, May 2007.

[43] See Massachusetts Division of Health Care Finance and Policy, "Massachusetts Health System Data Reference,"2009, showing that nearly 50% of emergency room visits were potentially preventable and that 8% of hospital admissions and 7% of hospital readmissions were potentially preventable.

Barriers to Effective Cost Control in the Current System

Researchers and policymakers have identified several cost drivers in the current health care system that impede current cost control efforts:

The existing financial incentives for providers promote increased spending.
For example,

- the development of supply leads to creation of demand;
- the predominant fee-for-service payment model encourages increased volume of services, not efficient patient care;
- the use of medical interventions, including technology and pharmaceuticals, instead of a focus on prevention and screening, drives up costs;
- the shortage of primary care physicians and the oversupply of specialists drive higher costs; and
- the delivery of services in the "wrong" locations.

The organization of the health care system promotes increased costs.

- most patient care is fragmented, with providers delivering uncoordinated care, which leads to duplication and lower quality;
- the system produces significant variation in care and generates too much care that is of low value to the patient;
- the system is built to address acute care, not chronic care; and
- providers and patients often do not work in partnership.

Many providers do not follow evidence-based medicine.

There is administrative waste in the system.

The system does not adequately engage consumers to make smart choices about health care services, including:

- failure of the system to fully value, embrace, and engage consumers as active participants in care;
- failure of the system to educate consumers about health care and activate consumers in shared care planning, decision making and self management;
- absence of resources and tools to help consumers navigate through the health care system in the most cost effective way;
- patient fears that limitations on service access will result in diminished quality;
- patient belief that more services will improve health; patent lifestyle choices that could curb the development of preventable diseases, and
- consumer financial costs lead to delay in accessing care.

Lack of cost and quality transparency.

Strategies for cost containment involve significant changes across all aspects of the health care system, including for the individual patient and provider. Successfully implementing these strategies will require significant ongoing commitment to and shared responsibility for change that will bring a common good in the form of reduced health care spending, but that at the same time will likely reduce the income and profitability of the health care sector, which employs 15% of the Massachusetts population.[44]

[44] Massachusetts Executive Office of Labor and Workforce Development, Commonwealth Corporation, "Massachusetts Healthcare Chartbook, Chart1, Fall 2007; available at: http://www.commcorp.org/researchandevaluation/documents/Healthcare_chartbook.pdf

Chapter 3: A Vision for a Redesigned Health Care System and Reduced Health Care Cost Growth

Vision

In striving for its goal to contain health care spending over the long term while maintaining or improving quality, HCQCC envisions a redesigned health care delivery system with the appropriate structure, incentives, and regulatory tools to promote the necessary changes. To maintain its position of leadership in health care reform nationally, it is essential for the Commonwealth to commit, as we did in our efforts to expand coverage, to a shared responsibility for cost control across our entire health care system. While much of the work will necessarily fall to providers, our system must support, encourage, reward and augment that work through the shared efforts and commitment of payers, consumers, employers, and government.

HCQCC envisions a system where patients have access to safe, high-quality, effective patient-centered care that is affordable and equitable. The system should be timely, efficient, and simple to administer. All providers should have and maximize use of health information technology (HIT). The system should promote the prevention and management of chronic diseases, seamless transitions between care settings, and end-of-life care in accordance with patient wishes. It should promote learning across providers and institutions while placing an emphasis on patient safety.

Consistent with a shared responsibility to control costs, the system should engage consumers in their own health care and promote healthy behaviors. At the same time, employers and insurers should offer products and benefits that encourage the use of high-quality, low-cost providers and services. Public and private payers should utilize payment strategies that provide incentives for an integrated and coordinated health care system. Both payers and government should reduce unnecessary administrative burden.

Conversely, in the redesigned system inequities, medical errors, preventable hospital admissions and readmissions, misuse, overuse, and duplication of services, and overpayments should be drastically reduced.

While HCQCC's vision focuses on long-term, sustainable changes to the health care system, HCQCC recognizes an urgent need to contain costs now. To that end, the Roadmap discusses strategies underway that have the potential to contain costs and additional strategies that may jump start cost containment efforts.

Principles and Criteria

To effectively contain health care costs and implement HCQCC's vision necessitates a change to the status quo. This change will impact many across the system and will ultimately lead to winners and losers as compared to the status quo. In selecting cost control interventions, HCQCC strived to develop a Roadmap for the state that includes a balance of integrated short-, mid-, and

long-term initiatives. The implementation of selected initiatives should be based on a transparent, data-driven process.

The cost containment strategies included within the Roadmap:

- possess clear and documented savings potential or compliment strategies with clear savings potential;
- focus delivery system attention on patient outcomes, efficient care delivery, and minimization of low-value services;
- maintain or improve quality, access, and disparities;
- give attention to both health care market issues and to public health;
- focus across the health care system and are complementary;
- strive for simplicity to the extent possible;
- are designed such that it is clear when, how, and by whom they are to be implemented, and what, if any, action should be taken by state government to support the effort;
- are designed with plans for evaluation for unintended consequences and for mid-course corrections, as necessary;
- require a shared effort by the health care delivery system, insurers, employers, consumers, and state government;
- have the support of key constituents who will need to be party to the change process; and
- are feasible to implement, both administratively and politically.

In addition to considering the principles and criteria articulated above in developing the Roadmap, HCQCC focused on developing interlocking strategies with interactive effects. The final recommendation of strategies includes an array of strategies that mutually reinforce HCQCC's overall vision for a redesigned health care delivery system.

Chapter 4: Work is Underway

Current Efforts to Improve Care and Reduce Costs

Despite the difficulties inherent in reforming the current system, there are literally hundreds of examples both in Massachusetts and nationally of collaborations and efforts to improve the quality of care provided to our residents and contain health care costs. This section of the Roadmap highlights key efforts underway in Massachusetts that can and should be leveraged as part of our collective effort to contain health care costs. Many of these efforts are limited in their ability to be brought to scale in the Commonwealth based on a combination of factors, including lack of authority and resources.

Table 4.1 below highlights some of the efforts in Massachusetts focusing on clinical efforts to improve care in ways that also are likely to reduce unnecessary system costs.

Table 4.1: Organizations and Groups Focused on Improving Care

Organizations/Committees	Area of Focus	Description
MA End-of-life Panel	End-of-life Care	Legislative panel charged with changing approach to end-of-life care; efforts are subsuming work of HCQCC's end-of-life committee
MA Patient-Centered Medical Home Initiative	Medical Home	Multi-stakeholder group, led by EOHHS, to develop a multi-payer medical home model across payers and providers
Employers Action Coalition for Health (EACH)	Comparative Effectiveness;	Employer led, eastern MA coalition with select participation by providers; all insurers involved; targeting one procedure at a time
Eastern Massachusetts Healthcare Initiative (EMHI)	Hospital-acquired infections; variation between hospitals	Multi-stakeholder initiative
MA Care Transitions Forum	Care transitions	Multi-stakeholder coalition, serves as subcommittee of Patient Safety committee for HCQCC; focused on improving care coordination across providers and care settings

STAAR	Care transitions	Commonwealth Fund/IHI grant (see description below)
RWJ Aligning Forces Grant	Care transitions	Robert Wood Johnson grant (see description below)

Table 4.2 below highlights a number of infrastructure and administrative efforts under way that, if implemented effectively, will reduce the time patients, providers, and payers spend focusing on administrative issues and allow more time for patient care.

Table 4.2: Organizations and Groups focused on Infrastructure and Administrative Efforts

Organization(s) and Groups	Area of Focus	Description
Massachusetts eHealth Institute MA HIT Council	HIT	Charged with ensuring all providers have interoperable EMRs by 2015
HealthyMass Compact	Administrative	State agencies focused on reducing administrative burden on providers/payers caused by duplicative or overlapping regulations and reporting requirements. Work ongoing
DOI Billing Simplification Group	Administrative	DOI was charged in ch. 305 to convene providers and payers to reduce billing differences across payers. Work ongoing
Employers Action Coalition for Health (EACH)	Eligibility Verification Simplification	Employer led, eastern MA coalition with select participation by providers; all insurers involved, including MassHealth
Eastern Massachusetts Healthcare Initiative (EMHI)	HIT	Multi-stakeholder initiative; this project focuses on IT interoperability

Finally, there are a number of efforts to engage consumers about their health care and to provide programs and incentives to lead healthier lifestyles. Table 4.3 below highlights some of those efforts.

Table 4.3: Organizations and Groups Focused on Consumers

Organization(s) and Groups	Area of Focus	Description
MA Department of Public Health (Mass in Motion)	Healthy Behaviors	A multi-pronged effort to induce healthy behaviors, including community grants; better school nutrition; BMI notices
Partnership for Healthcare Excellence	Consumer Engagement	Multi-stakeholder effort to conduct an educational campaign

Highlights of Current Efforts

As noted above, there are a multitude of ongoing efforts to improve quality and reduce costs in the Commonwealth. While many are impressive efforts, we have selected a handful to highlight here, falling into the following categories:

- Efforts that are so well underway that HCQCC believes that limited additional intervention is required, included potential statutory changes and monitoring of the ongoing efforts
  - Adoption of HIT
  - Administrative simplification
  - Promoting transparency

- Efforts that HCQCC believes can and should be leveraged as complimentary efforts to the recommended strategies described in Chapter Six
  - Patient Safety, including care transitions
  - End-of-Life Care
  - Partnership for Healthcare Excellence

Efforts Recommended for Monitoring Through the Roadmap

1. Health Information Technology

Widespread use of interoperable electronic health records is often cited as a strategy with great cost savings potential.[45] Chapter 305 of the Acts of 2008 includes a number of provisions aimed at the full implementation of electronic health records and interoperable networks by January 1, 2015. Specifically, Chapter 305 establishes the Massachusetts e-Health Institute (MeHI) for "health care innovation, technology and competitiveness.[46] The Health Information Technology (HIT) Council sits within the MeHI and consists of nine members. The Chair of the HIT Council is the Secretary of the Executive Office of Health and Human Services (EOHHS). With direction

[45] See, e.g., "Evidence on the Costs and Benefits of Health Information Technology," The Congressional Budget Office, May 2008; See also, R. Hillstead, J. Bigelow, A. Bower, F. Girosi, R. Meili, R. Scoville, and R. Taylor, Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings and Costs, *Health Affairs*, 24 (5): 1103-1117, 2005.

[46] See Section 4 of Chapter 305 of the Acts of 2008.

from the HIT Council, the MeHI is required to develop an annual statewide electronic health records plan, expected to be released in November 2009, which will include "community-based implementation plans that access a municipality's or region's readiness to implement and use electronic health record systems and an interoperable electronic health records network within the referral market for a defined patient population." The plan will consider "the development, implementation, and dissemination of electronic health records systems among health care providers in the community or region, particularly providers such as community health centers that serve underserved populations." The plans will further identify how the system will "allow seamless, secure electronic exchange of health information among health care providers, health plans, and other authorized users; provider consumers with secure, electronic access to their own health information; meet all applicable federal and state privacy and security requirements …; meet standards for interoperability …; give patients the option to allow only designated health care providers to disseminate their individually identifiable information, provide public health reporting capability… ; and allow reporting of health information other than identifiable patient health information" for certain purposes.

Further, Chapter 305 requires that the Board of Registration in Medicine define and include as a licensure requirement e-standard competency effective January 1, 2015. Likewise, the Department of Public Health must define and implement:

- Electronic standards for community health centers (CHCs) and hospitals for CPOE systems by October 1, 2012, and
- Electronic standards for CHC and hospital interoperability by October 1, 2015.

The HIT Council first began meeting in February 2009, and in addition to the work described above, is leading the Commonwealth's efforts to apply for and distribute federal funds, available through the American Reconciliation and Recovery Act (ARRA) of 2009, for further investment in HIT. A significant portion of the federal funding for HIT will be made as incentive payments to providers by Medicare for the "meaningful use" of electronic health records beginning in 2011. "Meaningful use" draft guidelines include performance measures related to quality, efficiency, and coordination of care. Additional funding will be available through the state Medicaid program and for planning grants.

Because of the lack of empirical evidence available to support cost-savings associated with implementation of HIT, and the likelihood that adoption and use of interoperable electronic medical records will not produce cost-savings in the next ten years, RAND attributes only a relatively small amount of savings ($3.6 billion over 10 years) to adoption of HIT. RAND notes, however, that the potential for savings when paired with system redesign, as many ideas to improve the health care system assume greater and more sophisticated used of information technology than is used today.[47]

[47]Christine E. Eibner, Hussey PS, Ridgely MS, and McGlynn EA. "Controlling Health Care Spending in Massachusetts: AnAnalysis of Options," The RAND Corporation, August 2009, p. 22.

2. Administrative Simplification

Simplifying administrative rules may seem like an easy task. However, state agencies, health insurers and providers have specific business reasons for their current functioning and any change to the status quo may trigger changes in the behavior of one actor. Trying to ferret out what requirements are necessary and what requirements are duplicative is tricky when similar requirements are utilized to monitor very different aspects of the health care marketplace.

Chapter 305 of the Acts of 2008 included a number of efforts to reduce administrative complexity in health care, including the Division of Insurance's (DOI's) effort related to uniform billing requirements by payers. Further, a number of significant voluntary efforts are underway such as the Patrick administration's Healthy Mass Compact and EACH's efforts to reduce administrative costs related to eligibility verification for both commercial and public payers.

HCQCC commends the Patrick administration's work to date to make efforts to reduce administrative burdens within the health care system and recognizes that it is difficult to make progress and remain committed to these projects given limited state resources. Despite these limited resources, a continued focus on efforts to reduce administrative complexity shows the state's commitment to do its part to reduce health care costs in the Commonwealth by easing regulatory burdens on payers and providers wherever possible. In addition, with the pending changes resulting from payment reform on the horizon, it will be important to keep administrative simplification on our collective minds as Massachusetts embarks on that effort.

While administrative simplification was included as one of the 21 strategies studied by RAND, it was not modeled based on limited evidence or studies in this area. RAND notes a general consensus that there is some unnecessary administrative cost within the system and identifies a number of areas where administrative spending may be reduced. These areas include billing, general management activities, sales and marketing, management of clinical care, and compliance with regulatory requirements. RAND does not differentiate administrative spending or aspects of potential savings between providers and insurers.[48]

3. Promoting Transparency

Significant efforts are well underway in the Commonwealth that promote transparency of data and analysis of health care quality and costs. HCQCC, since its inception, has been charged with collecting and making quality and cost data more available to consumers as well as the health care community. In addition to the efforts of HCQCC, a number of state agencies, including DHCFP, DPH, and DOI collect and report on various aspects of health care quality and cost. Chapter 305 of the Acts of 2008 expanded the efforts of DHCFP to include, among other things, collection of comprehensive data from public and private payers and to annually hold a public hearing focused on provider and cost trends. The Attorney General was also granted authority to participate in such hearings.

HCQCC will continue to monitor efforts to promote transparency. HCQCC believes that while these current efforts are a good start, there is still more to be done. HCQCC intends to expand

[48] Christine E. Eibner, Hussey PS, Ridgely MS, and McGlynn EA. "Controlling Health Care Spending in Massachusetts: AnAnalysis of Options," The RAND Corporation, August 2009, p. 27.

reporting capability on its public website, *My Health Care Options*. Also, HCQCC supports an expansion of DOI's current authority to provide the agency with the authority to not only disapprove unreasonable rates, but to affirmatively approve proposed health insurance premium rates, as well as to hold public hearings around the justification and impact of the proposed premium rates.

Efforts to be Leveraged as Part of Recommended Roadmap Strategies

Quality and Patient Safety

The Quality and Safety Committee of HCQCC is charged with leading HCQCC's efforts to improve the overall quality and safety of health care in Massachusetts. Specifically, the Quality and Safety Committee will identify opportunities for intervention, identify and align performance measurement, and track outcomes at the provider and system levels. The Quality and Safety Committee's ongoing work includes reducing hospital acquired infections, developing core components of patient safety programs across health care settings, improving care transitions, and improving care at the end of life. The Quality and Safety Committee and workgroup members include interested and active stakeholders who are trying to improve patient safety within their own institutions, practices, and organizations, as well as on a statewide basis. These quality efforts are aligned with HCQCC's concurrent efforts to contain costs.

1. Infection Prevention

In recent years, the Commonwealth has made improvements in its efforts to prevent infections, particularly in the hospital setting. Hospitals are required to report Hospital Acquired Infection (HAI) data to the Department of Public Health. DPH issued a public report of aggregated HAI data in April 2009. DPH is working towards issuing a report in February 2010 that will identify individual hospital HAI rates.

Currently, the infection prevention workgroup is focusing on three priority areas: ambulatory surgical centers; long-term facilities, including skilled nursing and independent rehab; and outpatient dialysis. Stakeholders are working together to develop process and outcome measures for public reporting.

2. Patient Safety Programs[49]

The goal of the patient safety workgroup is for all settings in which patient care is delivered to be required to establish a Patient Safety Program by January 2012. As envisioned by the workgroup, Patient Safety Programs "shall be designed to eliminate unnecessary risk to patients and to create a culture of patient safety." Further, the programs should be developed and implemented with applicable peer review protection. To be effective, responsibility for Patient Safety Programs must reside with the leadership of an organization as well as those delivering health care and must include the following elements:

[49] This section is based on information presented to the Health Care Quality and Cost Council at its May 20, 2009 meeting. See Patient Safety Programs Workgroup presentation by Jack Evjy, MD.

- assessment of risk to patients;
- development, implementation and improvement of policies, and
- a process for the review and analysis of all patient safety events

To accomplish this goal, the patient safety workgroup is focused on establishing standards for and increasing the adoption of Patient Safety Programs in all health care settings. The workgroup is actively working to develop a consensus for Patient Safety Programs across all health care settings and to develop core components and standards for such Patient Safety Programs. The workgroup anticipates having a recommendation for HCQCC's consideration by January 2010.

3. Care Transitions[50]

A number of important activities are occurring across the state to improve care transitions. The Care Transitions Forum has served as a subcommittee of HCQCC to provide statewide recommendations and direction to improve care transitions and to educate providers and other stakeholder on the plethora of care transitions projects occurring across the Commonwealth. The Forum meets quarterly and has over 100 members.

Reducing preventable hospital readmissions has been a main focus of care transition activities across the Commonwealth. Some activities include:

- *Division of Health Care Finance and Policy:* initiated a multi-stakeholder group to evaluate the 3M Potentially Preventable Readmission (PPR) tool.
- *STAAR Initiative*: A Commonwealth Fund/Institute for Healthcare Improvement initiative, Massachusetts is one of three states participating in this four-year initiative to reduce statewide 30-day rehospitalization rates by 30% and to increase patient and family satisfaction with transitions in care and with coordination of care. Project includes 16 hospital sites across the state; initial focus is on improving transition out of the hospital for all patients. In addition to hospitals, the STAAR initiative includes active participation with representatives of providers across the continuum of care, including skilled nursing, home health, ambulatory practices and caregivers.
- *Aligning Forces Grant*: In June 2009, a coalition of Boston-area stakeholders, including consumers, providers, payers, employers, and local government representatives was awarded a six-month planning grant of $200,000 from the Robert Wood Johnson Foundation to develop a plan of action to better align efforts and create concrete and long-lasting systems change that have an impact on the way care is provided, received, and paid for in the region. The grant is focused on helping physicians improve the quality of care, encouraging people to become better partners with their doctors, improving care inside hospitals, with special focus on the role of nurses, and reducing inequality in the care for patients of different races and ethnicities.[51]
- *Project RED*: Formally knows as the Re-engineered Hospital Discharge Program, Project RED is currently being tested at Boston Medical Center. The goal of the program is to

[50] Information included in this section was gathered in part from presentations given at the April 29th 2009 Massachusetts Care Transitions Seminar.
[51] Greater Boston Aligning Forces for Quality Initiative, Press Release, June 15, 2009.

improve care transitions by providing patients with tools and support to understand and manage their conditions as they are discharged from hospitals.[52]

The significant care transitions work occurring in the Commonwealth must be leveraged in implementing payment reform and system redesign across the state. Significant progress has been made and important lessons have been learned.

4. End-of-Life Care

Chapter 305 required the EOHHS to focus additional attention on care provided at the end-of-life. Following a recommendation of the HCQCC to implement a Physician Orders for Life Sustaining Treatment (POLST) program, Chapter 305 required that EOHHS implement a POLST pilot and that EOHHS convene an Expert Panel on the End of Life.

a. Medical Orders for Life Sustaining Treatment (MOLST) Pilot

To better convey its intent for use by all providers, the name of the program was changed to Medical Orders for Life Sustaining Treatment (MOLST). MOLST is a form to be used during an advance care planning process to promote better clinical training for clinicians on communicating with patients at the end of life; conversations between clinicians and patients about goals of care and treatment preferences as patients near the end of life; and standardized documentation about patient preferences to ensure a patient's wishes as to end-of-life care are communicated consistently across treatment sites.[53] The goal of utilizing a MOLST is to increase discussion of patient's preferences for end-of-life care, expand tools available for advance care planning processes, and reduce public and private spending on unwanted treatments at the end of life.[54] The MOLST pilot will be implemented in the Worcester area. Implementation steps are underway, including provider recruitment to participate in the pilot and finalizing the MOLST form. The pilot is scheduled to begin in the Fall 2009.

b. Expert Panel on the End of Life

The expert panel on end-of-life care brings together the work of the HCQCC's End-of-Life Committee, the Commission on End-of-Life Care, and the Betsey Lehman Center. Section 41 of Chapter 305 charges the panel to "investigate and study health care delivery for [patients with serious chronic illnesses] and the variations in delivery of such care among health care providers in the Commonwealth." According to a recent study by researchers at Dartmouth College, Massachusetts has among the highest spending on end-of-life care in the country.[55] The Expert Panel is charged with identifying "best practices for end-of-life care, including those that minimize disparities in care delivery and variations in practice or spending among geographic regions and hospitals. " The Expert Panel is due to release its final report in December 2009.

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[52] For more information about Project Red, see http://www.bu.edu/fammed/projectred/index html.
[53] Presentation to Expert Panel on the End of Life by Margaret Ann (Peg) Metzger, MOLST Project Consultant, July 23, 2009.
[54] Ibid.
[55] J. E. Wennberg, E. S. Fisher, D. C. Goodman, J.S. Skinner, Tracking the Care of Patients with Severe Chronic Illness, The Dartmouth Atlas of Health Care 2008, The Dartmouth Institute for Health Policy and Clinical Practice, April 2008.

The expert panel will leverage the significant efforts of the HCQCC's End-of-Life Committee as it puts together a plan to improve the outcomes and effectiveness of statewide palliative and end-of-life programs.

c. Potential of Improved Quality of End-of-Life Care to Contain Costs
While HCQCC's efforts are focused exclusively on improving quality of care provided at the end of life, RAND modeled potential savings related to decreasing the intensity of resource use for end-of-life care, the model excluded Medicare spending and focused instead only on end-of-life care spending in Massachusetts for those under age 65. As Medicare pays for 80% of end-of-life care, the resulting savings numbers without Medicare appear relatively small, at $1.4 billion over ten years. To determine the savings, RAND estimated the percentage of end-of-life care that would be provided in hospice care rather than in academic medical centers.[56]

Partnership for Healthcare Excellence[57]

The Partnership for Healthcare Excellence (the Partnership) is a statewide collaborative that includes health care organizations, labor, business leaders, and state government, focused on increasing consumer engagement in their care through a public education campaign. The goals of the Partnership are to:

- raise public awareness of the variations in health care quality;
- give consumers tools to improve the safety and effectiveness of their care by becoming more informed and involved; and
- mobilize consumers to advocate for safer, high-quality, more effective care.

To accomplish these goals, the Partnership has embarked on a statewide campaign that combines paid advertising, earned media, and a website to promote grassroots initiatives in communities and with employers. To date, the Partnership's education campaign is focused on medication errors, hospital safety and receiving the "right care." A key part of the Partnership's work is measuring the success of its efforts to date through consumer surveys. Based on early survey results, the Partnership's campaign appears to be increasing consumer awareness. Specifically, consumers in target markets seems to have more knowledge about what they should do to be a better patient, avoid medication errors, and fight infection.

The Partnership is now in the planning phases of expanding its message to include an "overuse" campaign, aimed at increasing consumer understanding of appropriate use of medical services and consequences of overuse. To date, the overuse campaign has targeted overuse of antibiotics and imaging. For these educational efforts, the Partnership has concluded that it is necessary to target both consumers and providers. For example, consumers require messages that reinforce the public and personal health risks associated with resistance to antibiotics; providers benefit from talking points and patient materials to provide consumers with alternatives and advice.

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[56] Christine E. Eibner, Hussey PS, Ridgely MS, and McGlynn EA. "Controlling Health Care Spending in Massachusetts: AnAnalysis of Options," The RAND Corporation, August 2009, p. 25.
[57] Information included in this section was gathered from a presentation to the Cost Containment Committee by the Partnership's Executive Director, Marilyn Kramer, on May 6, 2009 and information on the Partnership's website: www.partnershipforhealthcare.org.

The Partnership is also in the process of expanding its campaign to include education on end-of-life care.

HCQCC commends the Partnership for its commitment to engage and educate consumers, and believes that the Partnership's efforts play an important part in reducing health care cost growth by promoting consumer involvement in their care. The Partnership's efforts will go a long way to reinforcing the system redesign envisioned in this Roadmap. HCQCC urges the Partnership to continue its efforts and to expand its messages as appropriate to educate and engage consumers on the importance of such topics as care coordination, patient safety, evidence-based care, and healthy behaviors.

Medical Home Activity in Massachusetts

Massachusetts is undertaking a large multi-stakeholder patient-centered medical home project. Titled the Massachusetts Patient-Centered Medical Home Initiative (PCMHI), the effort involves all of the major private payers and MassHealth, representatives of the primary care community, purchasers, consumer advocates, and researchers. Beginning in June 2009, an advisory council consisting of over 50 individuals began an intensive planning process with a goal of implementation during 2010. The PCMHI is facilitated by EOHHS, which also provides project management support and funds the evaluation.

The PCMHI Council met seven times between June and October 2009 to develop a framework for the PCMHI. The framework will enable a smaller steering committee to subsequently develop more detailed plans, ultimately leading to the implementation of the initiative beginning in the late spring of 2010. The PCMHI Council focused its efforts on developing a framework for a multi-payer patient-centered medical home effort involving all the major Massachusetts commercial and Medicaid payers,[58] and a diverse group of primary care practices.

The objectives of the PCMHI are as follows:

1. Implement and evaluate the PCMH model as a means to achieve accessible, high-quality primary care.
2. Demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model.
3. Through successful implementation and future spread, help attract and retain primary care clinicians to practice in Massachusetts by increasing their compensation and quality of work life.

The framework is organized around four pillars: practice redesign, consumer engagement, incentive alignment, and evaluation.

Ultimately a series of practices will be selected through a competitive application process. Once selected, they will have technical assistance, including a learning collaborative and practice coaching, to help them transform their practices. They will also receive supplemental payments

[58] There is some hope that Medicare will participate as well given CMS plans for participation state-based medical home initiatives, but prospects are uncertain.

to cover the costs of transforming their practices and then operating them as patient-centered medical homes.

Other Current Efforts of Note

Affordable Health Plan
In July 2009, Senator Richard Moore, Senator Michael Moore, and Representative Harriet Stanley announced legislation[59] to create "The Affordable Health Plan" with the specific goal of providing small businesses with the option to purchase a product that may reduce premium costs by as much as 22 percent in the small and non-group market. As envisioned, the product would:

- be available in the small (50 or fewer employees) and non-group market, both through the Health Connector or directly from insurers;
- provide benefits actuarially equivalent to Commonwealth Choice Bronze level coverage;
- establish a statutory rate cap on reimbursements to all providers at no more than 110 percent of Medicare (or a rate actuarially equivalent to 110 percent of Medicare) for all covered services other than outpatient pharmacy benefits.
- limit post-tax underwriting surpluses to two percent and establish a minimum medical loss ratio of 85 percent for products offered by carriers in the small group/non-group markets
- prohibit providers from billing patients in excess of the reimbursement amount and established copayments, co-insurance or deductibles.
- prohibit providers from shifting costs to other products and charge the Division of Health Care Finance and Policy with monitoring provider charges and reporting noncompliance to the Attorney General.

The proposed legislation would sunset upon implementation of the Special Commission on the Health Care Payment System's recommendations.

[59] The legislation has not yet been assigned a bill number. Information about the proposed legislation comes from Senator Moore's July 22, 2009 press release, available at www.senatormoore.com.

Chapter 5: A Roadmap to Cost Containment

HCQCC puts forth the following Roadmap to Cost Containment. The Roadmap contains discreet strategies that HCQCC believes, if implemented strategically, will allow the Commonwealth to meet its goal of sustainably containing cost growth in health care while maintaining or improving quality. Much of the central work required to control health care costs, while maintaining quality, must be done by health care providers, as they redesign their organizations and processes of care to be more efficient and deliver better value. However, to be successful and have the maximum impact on cost and quality, we must create a system that supports, encourages, rewards and augments health care system redesign and population health management through the shared efforts and commitment of payers, consumers, employers, and government. This effort is not aimed at cost shifting from one constituency to another. It is aimed at sustainable cost control, the benefits of which accrue to all of us.

Specifically, HCQCC recommends:

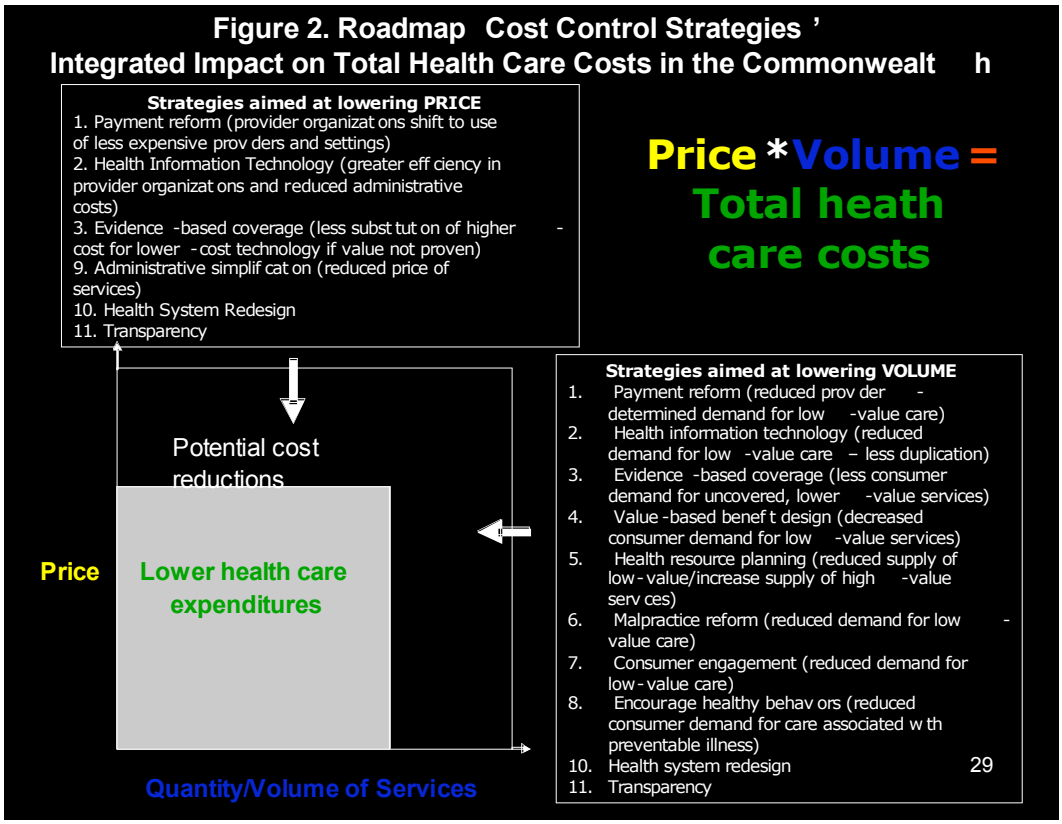
- Comprehensive payment reform
- Support of system-wide redesign efforts
- Widespread adoption and use of HIT
- Implementation of evidence-based health insurance coverage informed by comparative effectiveness research (CER)
- Implementation of additional health insurance plan design innovations to promote high-value care
- Development of health resource planning capabilities
- Enactment of malpractice reform and peer review statutes
- Implementation of administrative simplification measures
- Consumer engagement efforts
- Emphasis on the prevention of illness and promotion of good health
- Increased transparency

Each of these strategies has been shown to be effective in reducing health care costs, or cost growth, on a limited basis. Small-scale examples exist in Massachusetts and in other states. Here we are recommending full-scale, integrated implementation of the combined strategies for maximum impact in the Commonwealth.

Three of the strategies are underway. Current system-wide efforts exist to adopt and use HIT, increase transparency and to simplify administrative processes. Each of these current efforts will be monitored closely by HCQCC as part of HCQCC's enhanced monitoring efforts. The remaining eight strategies require planning and implementation.

Health care spending is a product of the price of health care services and the amount we use. Use is affected by both patients and providers. The strategies proposed here are intended to reduce both the amount of care we use and the price we pay for that care over time, thereby both increasing the efficiency of our health care system and reducing the rate of cost growth. It has been estimated that 20-30 percent of acute and chronic care provided in the United States is not

clinically necessary.[60] The strategies we propose are aimed first and foremost at reducing the amount of "low-value" care we provide and pay for, and are not intended in any way to result in reductions in or withholding of necessary health care. Figure 2 illustrates how we see these strategies affecting overall costs.



The Roadmap Strategies

Comprehensive Payment Reform

HCQCC believes that payment reform is central to controlling health care costs in Massachusetts. The current system of payments for health care services is dominated by fee-for-service, which is inherently inflationary, rewards overuse of health care services, does not reward primary care, preventive care, or care coordination, and contributes to administrative complexity.

The greatest potential for reducing the long-term health care cost trend in Massachusetts lies in changes to the composition and use of health care resources. The best way to achieve these savings is to develop a payment system that encourages and reinforces fundamental cultural and structural changes in our delivery system, such as:

[60] Becher EC and Chassin MR. "Improving The Quality of Health Care: Who Will Lead?" *Health Affairs*, 20(5), 164-179, 2001.

- Greater investments in primary care capacity;
- Increased use of nurse practitioners and physician's assistants, where appropriate;
- Promotion of the right care in the right place;
- Greater attention to prevention and wellness;
- Better management of chronic disease;
- Better integration of behavioral health care;
- Better coordination of care across care settings; and
- Capital investments and technology diffusion based on need, evidence, and quality.

HCQCC believes global payment models have the potential to provide appropriate incentives for efficiency in the delivery of services that are missing in the fee-for-service system, while strongly encouraging improvements in quality and access to appropriate, coordinated care. However, transition to global payments will take time, and there is an urgent need for control of health care cost growth.

We therefore recommend four components of payment reform:

1. Public and private payers should immediately increase use of payment methodologies that will support health care delivery system redesign, including:

    - increased use and alignment of pay-for-performance across providers and payers;
    - implementation of bundled or episode-based payments;
    - support for patient-centered medical homes; and
    - reduced payments for avoidable hospitalizations and preventable readmissions.

2. The state should encourage global payments as a major model for health care payments in Massachusetts. As suggested by the Special Commission on the Health Care Payment System, an independent Board should be established to guide and monitor the implementation of global payments. The implementation plan and timeline should recognize the complexities and address specific outstanding issues and challenges of global payments. The legislation should provide clear guidance to the Board as to the principles for its decision-making. Global payments should result in cost savings to both payers (employers, government) and consumers. Specifically, HCQCC recommends that the following issues must be addressed:

    - Development of standard global payment methodology
        a. Methodology for payments
        b. Methodology for risk adjustment
        c. Funds flow

    - What services are included?
        a. Traditionally under-resourced services such as mental health
        b. Catastrophic events
        c. Highly specialized services

- Roles of
  a. Public programs
  b. Self-insured

- Need for integrated provider organizations

- Definition of an accountable care organization (ACO) – accountable for what?
  a. Size and number of ACOs necessary to support coordinated care and avoid monopolies

- Provider infrastructure costs and source of funding

- Risk assumed by ACO's versus insurance plan

- Experience of consumers
  a. Choice
  b. Out-of-pocket costs
  c. Premiums

- Potential anti-trust and other legal issues

- Payment for
  a. Hospital stand-by services
  b. Education
  c. Research
  d. Disproportionate share institutions

- Oversight authority
  a. Specific role
  b. Accountability
  c. During transition and after

3. HCQCC should monitor cost growth and the Division of Health Care Finance and Policy should explore government options for rate regulation if cost control targets are not met. In case there is limited progress toward global payments or set targets are not met, HCQCC shall request DHCFP to report back to HCQCC within six months of the request regarding progress toward cost control goals and the potential impact of rate regulation in meeting these goals more rapidly.

4. The Commonwealth should continue efforts to work with CMS on system redesign initiatives, including implementation of medical homes and efforts to efficiently provide coverage to Massachusetts residents that are dually eligible for Medicare and Medicaid. Further, the state should work with CMS to utilize its Center for Innovation to include Medicare's participation in payment reform efforts in Massachusetts.

Ideally, implementation of payment reform should:

- Occur on a statewide basis;
- Be implemented across all public and private payers;
- Provide for an appropriate transition period;
- Include technical support for providers; and
- Have as a goal reducing cost-shifting between public and private payments.

HCQCC places particular emphasis on the promise that payment reform will create incentives for providers to better coordinate care on behalf of their patients across care settings. In a redesigned health care system, HCQCC believes that quality of care provided to patients will improve and that unnecessary emergency room visits, preventable hospital admissions and hospital readmissions will be reduced. System-wide use of interoperable HIT is necessary to fully realize this transformation in care delivery.

HCQCC also believes that it is essential to identify and track system-wide cost and quality measures that will allow the Commonwealth to both gauge the effects of payment reform and ensure that providers are held accountable for providing high-quality care. HCQCC's recommendations for quality and cost monitoring are described below.

Implementation Activities and Costs

Implementation of payment reform will be a complex undertaking, requiring considerable effort on the parts of state government, providers and payers. The initial required steps are as follows:

1. Development and passage of legislation that
   a. creates a payment reform oversight entity, and provides it with necessary funding and staffing support;
   b. addresses any necessary statutory changes to help facilitate the implementation of the new payment system, including addressing anti-trust provisions if required; and
   c. includes the implementation of regulatory rate controls if sufficient movement is not made in implementing payment reform by a date certain.

2. Provision of necessary infrastructure support to providers lacking substantial experience with integrated service delivery or demonstrated success managing care under a global payment arrangement.

3. Development of key policy decisions by the oversight entity, all informed by a comprehensive process of soliciting and incorporating stakeholder input.

4. Appropriation of sufficient funds to support the oversight entity and technical support to providers.

Why is Payment Reform Necessary?

As described above in Chapter Two, health care costs are growing at an unsustainable rate. Health policy experts nationally feel that payment reform is the strategy most likely to improve

the United States health care system,[61] and for good reason. Absent movement away from a system of predominantly fee-for-service payment, providers will continue to face powerful economic incentives to increase the volume of services that they deliver, as well as to emphasize the delivery of those services that are most profitable. Furthermore, they will not face any economic incentives to manage the overall care of their patients, protect against the potential dangers and costs of overuse, or ensure appropriate transition planning between care settings.

Payment reform can result in not only the reduction, if not removal, of the incentive for ever-increasing volumes of services, but can also positively influence the organization of care delivery from its currently relatively fragmented structure to one that is better integrated, providing care that is both more effective and efficient.

HCQCC believes that payment reform is an essential ingredient to achieving cost containment in Massachusetts.

Including Medicare as Part of the Payment Reform Effort

Medicare is a substantial health care payer in Massachusetts. According to the latest available data from CMS, Medicare accounts for:

- 27.8% of hospital revenues,
- 17.7% of physician and clinical services,
- 24% of other professional services,
- 25.6% of home health care, and
- 24.2% of durable medical equipment.

Where it is such a key part of a provider's revenue stream, any payment reform strategy adopted by the Commonwealth will have a significantly greater chance of success if Medicare participates. Having all payers participate in reform will allow for financial incentives to be aligned across all payers and can lead to meaningful and sustainable system redesign. Medicare recognizes this and has expressed its support of Massachusetts' efforts to implement payment reform and its interest in participating in it.

Like all payers, Medicare too is grappling with the continuing rise of health care costs and is beginning to work toward a process of reforming Medicare payments in the next few years. Some initiatives are already announced and underway, while others are likely to result from pending federal health reform legislation. A brief summary of pending and anticipated initiatives follows.

1. CMS Medical Home Demonstration
   Section 204 of the Tax Relief & Health Care Act of 2006 mandated a demonstration in up to eight states to provide "targeted, accessible, continuous and coordinated care to Medicare beneficiaries with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment." CMS anticipates soliciting 50 practices in each of the

[61] K. Stremikis, S. Guterman, and K. Davis, Health Care Opinion Leaders' Views on Payment System Reform, The Commonwealth Fund, November 2008.

eight states for a total of 400 practices. A CMS official has reported that the eight states have been selected, but that CMS is still awaiting approval from the White House Office of Management and Budget in order to move forward with the project.[62]

2. CMS Medicare Advanced Primary Care Demonstration
   Health and Human Services Secretary Kathleen Sebelius announced on September 16, 2009 that Medicare would be participating in state-based medical home initiatives involving Medicaid and private purchasers.[63] CMS will develop solicitation documents for states in the fall of 2009, and intends to start the demonstration in 2010. The demonstration is based on Vermont's medical home initiative. Massachusetts is currently participating in a New England state coalition involving Vermont and the other four states in the region to coordinate medical home initiatives.

3. CMS Acute Care Episode (ACE) Demonstration
   The ACE Demonstration will test the effect of bundling Part A and B payments for episodes of care to improve the coordination, quality, and efficiency of that care. Eligible organizations are defined as entities, including an affiliation between at least one physician group and at least one hospital, routinely providing the procedures included in the demonstration. The demonstration is being phased in with health systems in four southwestern states in 2009.

4. CMS Post Acute Care (PAC) Payment Reform Demonstration

   The PAC Payment Reform Demonstration began in 2008 with a report to be submitted to Congress in 2011. The goal of this initiative is to standardize patient assessment information from PAC settings and to use these data to guide payment policy in the Medicare program.

5. Senate Finance Committee Bill: Shared Savings Arrangements with ACOs
   The Senate Finance Committee chaired by Senator Max Baucus has approved a bill that calls for Medicare allowing groups of providers to form ACOs and to share in cost savings with Medicare. Specifically, actual expenditures for a defined patient population would be compared to risk-adjusted actual spending to determine possible shared savings. The initiative would begin January 2012.

6. Senate Finance Committee Bill: Payment Model Testing
   The Senate Finance Committee also called for the creation of an Innovation Center within CMS, whose purpose would be to "facilitate the timely design, implementation and evaluation of payment models." The bill anticipates use of medical home, comprehensive (global) payment, and other models. It also specifically states that the Innovation Center should "allow states to test and evaluate systems of all-payer reform for medical care of residents in each participating state, including individuals dually eligible for Medicare and Medicaid."

[62] http://diseasemanagementcareblog.blogspot.com/2009/05/update-on-medicare-medical-home html
[63] http://www hhs.gov/news/press/2009pres/09/20090916a html

7. Senate Finance Committee Bill: National Pilot on Payment Bundling
   The Senate Finance Committee requires CMS to conduct a demonstration involving the use of episode-based, or "bundled," payments for Medicare beneficiaries. The Secretary of HHS would select eight conditions for the pilot program.

Barriers to Implementing Payment Reform

The challenges to implementing payment reform are manifold. Payment reform will impact perhaps every provider in the Commonwealth. While many will view it as an opportunity to right a seriously flawed system, others will view it as a threat to their financial health. For this reason, HCQCC urges cautious, planned implementation of global payment, while taking steps to implement short-term strategies to improve the current payment structure and incentives.

A second barrier will be the need to consider and address many complex methodological issues, including how to risk adjust global payments and use other risk modification devices to ensure that providers are responsible only for performance risk, not insurance risk. Examples of other issues include how to structure access and quality performance incentives as part of the global payment methodology, and how to set the three milestones set forth in the Special Commission on the Health Care Payment System's report. These barriers can be overcome, but will require significant broad-based effort.

A third barrier will be possible unintended consequences. Moving to global payments will require unprecedented change. Even the best planning effort could still result in consequences that were not anticipated, and worse, not desired. For this reason HCQCC intends to closely monitor progress towards implementation of global payments, on top of the necessary measurement and monitoring that occurs by a payment reform oversight entity, if one is to be created, as recommended by the Special Commission.

Cost Savings Potential

Despite decades of experimentation with provider payment systems, there is very little sound research evidence to support estimates of the impact of a new global payment system, as envisioned by the Special Commission, on Massachusetts health care costs. Economist Jamie Robinson wrote:

> "The complex and rapidly changing organizational and contractual environment of physician payment does not lend itself to easy study. Analyses have been plagued by incomplete data, thorny methodological challenges, and inadequately developed conceptual frameworks. Due to time and space limitations, surveys often restrict themselves to simple questions…despite the recognized existence of hybrid and blended payment mechanisms. The observed association between payment mechanism and physician behavior often is confounded by endogenous and poorly measured non-price features of the relationship, ranging from physician and patient self-selection to monitoring mechanisms and group culture."[64]

[64] James C. Robinson. "Theory and Practice in the Design of Physician Payment Incentives," *The Milbank Quarterly*, Volume 79 Number 2, 2001.

There are almost no experimental or quasi-experimental studies with capitation in the United States,[65] let alone with "global payment," as envisioned by the Special Commission. Where research has been performed using other methods, it has generally shown that risk-sharing with providers results in reduced service utilization and costs relative to fee-for-service payment. Most of this research was performed studying the capitation arrangements in use in the late 1980s and early 1990s.[66]

Other research conducted during this time period to examine the impact of provider risk-sharing on access, quality and patient and provider satisfaction showed mixed results. This research, like that conducted to assess impact on utilization and cost, varied greatly in terms of the research design, the populations and practices being studied, and the payment model itself.[67]

RAND estimated potential savings from alternative payment approaches for the Division of Health Care Finance and Policy, but did not include global payment among the strategy options that it considered. RAND estimated a savings range of 0.1% to 5.9%, exclusive of Medicare, for episode-based, or "bundled," payments based on the assumption that there would be a 50% discount on services related to potentially avoidable complications. The lower-bound savings figure assumes implementation with four hospital-based procedures, while the upper-bound estimate also includes rates for six chronic conditions.[68]

While there is no sound basis for estimating the cost savings to be achieved through the implementation of global payment as the predominant payment system in Massachusetts, the Special Commission agreed that global payment was likely to be more effective controlling costs than episode-based payments for procedures, since such payments would not provide a financial incentive to avoid the need for procedures, or for their being repeated. The Special Commission also felt that global payment could be implemented more broadly, more rapidly and with more confidence than episode-based payments for conditions and procedures, since the only existing, operational episode-based model (PROMETHEUS Payment) only began piloting in 2009.

Conclusion

HCQCC believes that payment reform, and specifically movement away from fee-for-service payment as the primary payment methodology in use in the Commonwealth, is absolutely necessary in order to make progress towards HCQCC's cost containment goals. Payment reform is necessary, but not sufficient, however. It must be accompanied by the other strategies described in this Roadmap, recognizing that there is no "single bullet" means to containing health care costs in Massachusetts.

Widespread Adoption and Use of Health Information Technology

HIT is necessary infrastructure to improve the quality of care provided to patients and improve efficiency. HIT has the potential to reduce unnecessary and duplicative testing, reduce the

[65] Meredith Rosenthal, personal communication, July 10, 2009.
[66] Mathematica Policy Research. "Appendix C.2 Global Payment," from Recommendations of the Special Commission on the Health Care Payment System, July 16, 2009.
[67] Ibid.
[68] Christine E. Eibner, Hussey PS, Ridgely MS, and McGlynn EA. "Controlling Health Care Spending in Massachusetts: AnAnalysis of Options," The RAND Corporation, August 2009.

administrative burden on providers, and improve clinical quality.[69] Significant work is underway. As described more completely in Chapter Four, the Massachusetts eHealth Institute (MeHI) and the HIT Council are charged, through Chapter 305 of the Acts of 2008, with ensuring that all providers have and utilize electronic health records and interoperable networks by January 1, 2015. Likewise, the federal government, through the ARRA, is funding efforts to support the adoption of meaningful use of interoperable electronic health records and to develop the capacity for widespread health information exchange. MeHI and the HIT Council will also monitor these efforts.

HCQCC will closely monitor progress towards this goal as part of its Roadmap and assess the need for any additional intervention.

Implementation of Evidence-Based Health Insurance Coverage Informed by Comparative Effectiveness Research

HCQCC has identified overuse of health care services, or low-value care, as a significant factor in health care cost growth.[70] Furthermore, overuse sometimes results in harm to patients and their families. Comparative effectiveness research (CER), which provides information on the relative strengths and weakness of medical interventions to support provider and patient decision-making, has been used successfully to reduce unnecessary care.[71] CER is used to evaluate whether the research evidence demonstrates clinical effectiveness of a specific treatment or intervention for a defined population(s). CER also considers the comparative clinical and cost effectiveness of the service relative to other service alternatives.

HCQCC believes that available comparative effectiveness information and analysis should be utilized to develop consensus recommendations for coverage and medical necessity policies in Massachusetts that could be implemented across private and public payers. HCQCC, therefore, recommends the creation of an entity governed by a board consisting of providers, consumers, payers, employers, and clinical experts. The entity could be state-based, or part of a regional collaborative as is being considered pursuant to Chapter 305 of the Acts of 2008.

The entity would not conduct effectiveness studies, but would leverage existing efforts currently used by the Commonwealth's payers, and would either directly or through contract synthesize existing CER findings. It would disseminate these syntheses to insurers, employers, providers, and consumers. In addition, it would develop or identify tools or resources to assist in the implementation of its findings and recommendations, including how to address individual patient cases and circumstances.

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[69] "Evidence on the Costs and Benefits of Health Information Technology," The Congressional Budget Office, May 2008.

[70] See, e.g., "An Agenda for Change, Improving Quality and Curbing Health Care Spending: Opportunities for Congress and the Obama Administration," A Dartmouth Atlas White Paper, Dartmouth Institute for Health Policy and Clinical Practice, December 2008.

[71] For example, hormone replacement therapy (HRT) in women was a popular treatment for menopause in the 1990s, prior to a large-scale clinical trial which showed that HRT imposed health risks that exceeded its benefits. Following the study, usage of HRT declined by 43%. See MedPAC. Report to Congress: Reforming the delivery system. Washington, DC: MedPAC; June 2008.

The entity would focus its efforts on those services for which the highest levels of overuse are suspected, with specific attention to services for which overuse is resulting in significant patient harm, and/or high expenditures. This strategy would create consistency in medical policy across payers, which would reduce the administrative burden on providers and administrative costs to the payers. As appropriate, the entity may focus on dissemination about underuse of services where it impacts the public health.

DHCFP and DOI should convene the participants in this effort for initial discussion and develop an action plan.

There are a few examples of state-initiated efforts to make greater use of evidence in setting coverage policy.

Washington State

The Washington State Health Care Authority by statute (RCW 41.05.013) administers a Health Technology Assessment Program to develop coverage policy for three state agencies that directly purchase health care: Medicaid's fee-for-service program, workers' compensation, and the public employee self-funded plan. An independent clinician panel makes coverage decisions. The Health Technology Assessment Program works closely with the three state agencies around topic nomination and prioritization as well as collection of utilization data. The state's 18-month assessment found that the program had saved the state over $20M addressing seven procedures: upright MRI, pediatric bariatric surgery (< 18 years), pediatric bariatric surgery (18-21 years), lumbar fusion, discography, virtual colonoscopy, intrathecal pumps, and arthroscopic surgery of the knee. The committee concluded that evidence on five of the services did not currently demonstrate net health benefit and therefore should not be covered. Two technologies had evidence that demonstrated net health benefits in some circumstances, and are covered with conditions.[72] More recently, the state estimated that its savings were between $40-60 million.[73]

Preceding the creation of the Health Technology Assessment Program (HTA), and continuing for those services not addressed by the HTA, is one administered by the state's Medicaid agency. The Washington Department of Social and Health Services (DSHS) has long been a leader in the rigorous implementation of an evidence-based coverage policy. Backed by a regulatory requirement to apply an evidence-based approach to coverage policy (WAC 388-501-0165),[74] DSHS grades individual services based on the quality of the evidence supporting their effectiveness.

[72] Personal communication with Leah Hole-Curry, Washington Healthcare Authority, August 12, 2009 and Washington Healthcare Authority document titled "HEALTH TECHNOLOGY ASSESSMENT PROGRAM: PAYING FOR HEALTH CARE THAT WORKS," undated.

[73] Presentation of Jane Beyer, Senior Counsel, Democratic Caucus, Washington State House of Representatives and Jeff Thompson, Washington Healthcare Authority, at the National Association of State Health Policy (NASHP) payment reform pre-conference, October 5, 2009.

[74] Missouri and Tennessee also have such statutory language for their Medicaid programs, although they have not utilized it to implement a true evidence-based coverage strategy to the degree exhibited by Washington.

As defined in regulation, one of four grades is assigned a service based on the assessed evidence. This method has been adapted from that used by Hayes, a commercial vendor that performs evidence-based reviews for payers.

A = Randomized controlled clinical trials
B = Consistent and well-done observational studies
C = Inconsistent studies
D = Studies show no evidence, raise safety concerns, or no support by expert opinion

DSHS generally approves "A" and "B" services for coverage. "C" and "D" services are approved only upon special case-specific review. The details of this process are provided in regulation WAC 388-501-0165, providing significant regulatory support for the state and improving the state's performance in fair hearings. Service-specific authorization policies are published in bulletins and billing instructions.

The state of Washington has performed some analysis of the cost-effectiveness and savings deriving from these activities:

- reduction in bariatric surgery spending from $970K in 2003 to $56K in 2006 (94% reduction);
- reduction in enteral nutrition spending ($10M savings), and
- reduction in attention deficit disorder drug spending for children through required second opinions, resulting in a 3:1 return on investment.[75]

In order to generate support for its work, DSHS decided to lead with patient safety, focusing its early policy setting on overuse situations that threatened patient health and safety, initially avoiding the most politically charged topics.

Minnesota

Minnesota made a strategic decision to invest more heavily in an evidence-based coverage policy in recent years and hired a physician to lead the effort. The state participates in the Medicaid Evidence-Based Decisions (MED) Project, an offshoot of the Drug Effectiveness Review Project (DERP), which, like the DERP, is staffed by Oregon Health and Sciences University, an AHRQ Evidence-Based Practice Center. Minnesota relies heavily upon the MED Project and its reviews to inform its activities.

The state of Minnesota works with a stakeholder-populated Health Services Advisory Council, created by statute, which participates in the consideration of evidence reviews to set state coverage policy. Once a year the state asks HCQCC for "hot topics," looks at the services being assessed by the MED Project, and then examines its own internally developed list, to generate an agenda for the fiscal year. Minnesota began to implement this approach a couple of years ago and has not yet implemented its fiscal impact, but will be doing so in the fall of 2009 per a

[75] Personal communication with Jeff Thompson, MD, Washington Department of Social and Human Services, July 12, 2004 and on other occasions.

legislative directive. A list of services reviewed by the Health Services Advisory Council since 2006 can be found in Attachment A.

Implementation Activities and Costs

The creation of an independent non-profit entity to advance consensus policy development and implementation regarding evidence-based coverage[76] in Massachusetts would require the following:

1. legislation requiring DHCFP and DOI to convene the participants, and support the entity's formation;

2. legislation requiring MassHealth to participate as a member of the independent non-profit entity;

3. development of a board of providers, consumers, payers, employers and clinical experts;
4. funding by participating payers;

5. development of a set of policies and procedures to govern the entity; and

6. determination of the means by which analyses of research will be conducted and communicated.

Why is Evidence-Based Coverage Necessary?

HCQCC identifies two primary supporting arguments for evidence-based coverage: 1) the extent of overuse in the health care system, and 2) the limitations of existing strategies to address overuse.

The extent of overuse in the health care system

Extensive research over the past 30 years has highlighted the considerable variation in medical practice that exists within and across states. As highlighted by Atul Gawande's attention-grabbing June 2009 *New Yorker* article,[77] certain communities experience utilization and costs that are multifold the rates experienced in other communities.

John Wennberg, a pioneer in this field of study has observed "We've known for some time that in health care, geography is destiny. How much care you receive often depends on where you live. What's striking is that these differences exist not just between states, but within cities, and even within neighborhoods."[78]

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[76] The decision of whether to cover a service under the terms of an insurance policy is one of *coverage policy*. The decision of whether to make a covered service available to an individual patient is a *medical necessity determination*. For the purposes of the Roadmap, evidence-based coverage refers to both coverage policy and medical necessity determinations.

[77] Atul Gawande. "The Cost Conundrum," *The New Yorker*, June 1, 2009.

[78] "New Reports Show Cost of Medical Care Still Varies Widely Across California," California HealthCare Foundation press release, April 7, 2008.

Research has revealed that these differences do not reflect differences in patient populations, but rather differences in numbers and types of health care providers, and differences in community practice styles.

The variation is not benign. Elliot Fisher and colleagues at Dartmouth College have shown that in Medicare there is an *inverse* relationship between health care spending and health care quality. That is, the communities with the highest Medicare utilization and spending have *higher* risk-adjusted mortality rates than those with the lowest utilization and spending. More care and more spending produce poorer-quality health care in their analysis.[79]

Experts estimate that somewhere between 25 and 50% of all United States health care spending produces no benefit to the patient—and some of it clearly produces harm. The RAND Institute's estimate is 30% of total national health care spending ($700B), or the size of the entire high technology industry.

The limitations of existing strategies to address overuse.
Every public and private payer of heath care services utilizes an evidence-based approach to determine whether a service should be covered, and if it should, under what circumstances.

Payers routinely consider evidence when considering newly introduced services. Payers may decide to cover a service following internal review of evidence or perhaps when an external entity (e.g., Medicare or a private review entity) has conducted such a review and rendered a judgment. The rigor of these efforts, however, is highly variable across payers. Many payers make only a modest investment in evidence review.

If a payer decides to cover a new service, it may then create medical necessity criteria that must be met in order for the service to be covered, and administrative procedures (e.g., service authorization) to make those determinations. Payers have long administered procedures for assessing medical necessity. Many of these were dramatically scaled back during the "managed care backlash" period that began in the late 1990s. While some service authorization processes have been reintroduced since that time, e.g., for high-end diagnostic imaging, the level of insurer intervention remains below what it once was. Insurers have instead attempted to use other instruments to control cost, such as increased cost-sharing and disease management. Providers continue to possess significant discretion to provide services as they deem medically necessary.

Barriers to Evidence-Based Coverage
There are a number of barriers to implementing evidence-based coverage as envisioned by HCQCC.

1. *Provider supply in Massachusetts*: Fisher and his Dartmouth College colleagues have identified health care provider supply as a significant contributor to overuse in the Medicare population.

[79] Elliot Fisher, Goodman D, Skinner J, Bronner K. "Health care spending, quality and outcomes. More isn't always better." The Dartmouth Institute for Health Policy and Practice. See www rwjf.org/files/research/spending022009.pdf, accessed August 3, 2009.

"the additional services provided to Medicare beneficiaries in higher-spending regions all fall into the category of "supply-sensitive care": discretionary care that is provided more frequently when a population has a greater per capita supply of medical resources. Higher-spending regions have more hospital beds (especially intensive care unit beds), more physicians overall, and more specialists per capita. Patients in high-spending regions are hospitalized more frequently, spend more time in the ICU, see physicians more frequently, and get more diagnostic tests than identical patients in lower-spending regions."[80]

Massachusetts ranks first in the country in physicians per capita.[81] While many work part time in academic institutions, Massachusetts is still 74% above the national median.

2. *Provider and patient resistance*: While organized medicine has recently been adopting positions that are generally supportive of the use of evidence to inform care delivery,[82] it has not been supportive of using evidence to inform coverage decisions, preferring physician autonomy to make treatment decisions. In general, providers poorly receive payer efforts to limit their autonomy and treatment decisions and both providers and manufacturers lobby against efforts to impose constraints. Patients have long objected to any limitations on access to services, even when there is evidence of ineffectiveness.

3. *The need for cooperative effort*: While Massachusetts is distinguished by the extent to which the health care sector participates in cooperative activity, the creation of this non-profit entity would be a significant effort requiring broad participation and the commitment and patience to work through difficult decisions.

4. *Scope of the task*: There are thousands and thousands of services, making the process of both reviewing the effectiveness and benefit of new services and periodically re-reviewing the evidence a huge resource requirement for any payer. For this reason, many payers give minimal consideration to research on the efficacy of existing services.

5. *Limitations of evidence*: Evidence is lacking altogether for many services. Evidence particular to subpopulations (e.g., gender, age, ethnicity, condition) is absent in most cases. In addition, when there is evidence, it is frequently nuanced. Carolyn Clancy, Director of the Agency for Healthcare Research and Quality, has said: "we haven't had a study yet that found one option is terrific and the other is thumbs down. It's always shades of gray, just like in real life."[83]

Cost Savings Potential

With overuse so prevalent in the health care system, even a small reduction would generate large savings. Nonetheless, in its analysis for the Division of Health Care Finance and Policy, RAND was unable to attribute a specific savings figure to the increased use of comparative effectiveness

[80] Op. cit., Fisher et. al.
[81] www.statehealthfacts.org, accessed August 3, 2009. Massachusetts also ranks first in the country in dentists per capita, second in RNs per capita, and eighth in ER visits per capita. Massachusetts ranks lower in terms of hospital beds per capita, however, where it is has the 27th highest number of per capita beds per 1000 among the 50 states.
[82] www.ama-assn.org/ama/no-index/news/rhetoric-reality-stimulus-package.shtml, accessed August 3, 2009.
[83] Melinda Beck. "Injecting Value Into Medical Decisions," *The Wall Street Journal*, pp.D1-D2, July 28, 2009.

information because RAND "could find no empirical studies or other relevant data to inform systematic analyses."[84] When presenting to HCQCC on August 7, 2009, Beth McGlynn of RAND explained that RAND was limited also by the uncertainty of a) what comparative effectiveness analysis would yield, and b) how the information would be applied.

Conclusion

The dollar value attributed to the delivery of services that produce no value to patients, and sometimes produce harm, is staggering. HCQCC believes that any efforts to reduce health care costs in Massachusetts must include an effort to reduce production of services that produce no benefit. Because of limitations in the quantity and quality of evidence, and the fact that many services produce some benefit to some patients, an effort to more rigorously apply evidence to coverage policy and medical necessity determinations will be as challenging as it is necessary.

Implementation of Additional Health Plan Design Innovations to Promote High-Value Care

Some employers have shown significant cost reductions by introducing financial incentives and supportive outreach programs that promote employee health. These programs usually provide incentives for at-risk or high-cost populations of employees to use services that are proven to be of "high value": they improve health and reduce costs. Programs also have used financial incentives to encourage the use of more efficient and higher-performing providers. Despite the success of these programs, so-called value-based benefit design has not diffused throughout the Massachusetts market.

HCQCC recommends that the Division of Insurance (DOI), jointly with the Executive Office of Health and Human Services (EOHHS) and Massachusetts employer and consumer representatives, convene a standing committee charged with developing and deploying throughout the marketplace innovative insurance products, which utilize value-based benefit design principles. The standing committee should look to promote existing and develop new products that provide meaningful incentives to consumers, which will lead to improved health outcomes and reduced premium cost. The standing committee should also identify barriers to the promotion of new products, including flexibility in network adequacy requirements and opportunities to allow for more expeditious review of plan submissions by the DOI.

It is important to distinguish this strategy from prior strategies utilized by employers to lower their businesses' health care costs. In the past, employers have realized cost savings by shifting costs to employees through increased copayments and the introduction of high-deductible health plans. Research has found that shifting costs to employees can create financial barriers to receiving necessary care. Specifically, research has shown that copayment levels have a direct impact on whether certain patients fill their prescriptions, with the rate of filling prescriptions declining as copayment levels increase.[85]

[84] Christine E. Eibner, Hussey PS, Ridgely MS, and McGlynn EA. "Controlling Health Care Spending in Massachusetts: AnAnalysis of Options," The RAND Corporation, August 2009.
[85] Goldman DP, Joyce GF, and Karaca-Mandic P. "Varying pharmacy benefits with clinical status: the case of cholesterol-lowering therapy" *American Journal of Manage Care*, vol. 12, pages 21-28 (2006).

Employers working with health plans have opportunities today to steer their enrollees through the use of financial incentives and supportive outreach programs to higher-value services that promote employee health. To make these changes, an employer must be aggressive in promoting employee health and creating a wellness culture that supports changed enrollee behavior. This requires a long-term commitment and strong leadership. Employers with a strong union presence will also need to work cooperatively with union leadership to promote the benefit of these changes and provide opportunity for unions to promote these benefits to their membership.

Implementation Activities and Costs

The creation of a standing committee convened by the Division of Insurance (DOI) would require the following:

1. legislation requiring DOI to convene a standing committee (note this step may not be necessary, but having the committee be legislatively required will make it more likely to convene on a regular basis);

2. clear definition of vision and goals of the standing committee;

3. clear delineation of responsibilities of standing committee;

4. clear responsibilities for DOI's actions based on the standing committee's recommendations;

5. appointment of entities and designees to the standing committee, and

6. scheduling of monthly meetings and agendas.

Why is a standing committee focused on Health Plan Design Innovation necessary?

An emerging employer movement in benefit design, referred to as value-based benefit design, uses financial incentives to motivate patients to obtain needed services, or initiate certain health-supporting behaviors, as a way to improve health status and thereby reduce costs. Massachusetts' major insurers are offering, to different degrees, value-based benefit design products and services.[86] While a number of products that have innovative aspects are available in the health care marketplace, employers currently make limited use of them. Examples of consumer incentives that may be included in value-based benefit designs include:

- reduced cost-sharing for using a high-value provider;
- reduced premiums for choosing plans with selective networks;
- reduced or eliminated cost-sharing related to prescriptions or office visits to manage chronic diseases, and

[86] For detailed information on the value-based benefit design elements offered through BCBSMA, Harvard Pilgrim, Tufts, Fallon and Health New England, see Bailit's memorandum to the Cost Containment Committee entitled Value-Based Benefit Design, Strategy Options for Massachusetts Employers, Revised May 1, 2009, accessible on HCQCC's website at: http://www.mass.gov/?pageID=hqccterminal&L=4&L0=Home&L1=The+Council&L2=About+the+Council&L3=Meeting+Schedule+and+Materials&sid=Ihqcc&b=terminalcontent&f=cost_containment_committee&csid=Ihqcc

- free or low-cost wellness benefits, including smoking cessation, gym memberships and weight loss plans.

In addition to serving as a forum to promote these innovative product designs, the standing committee also can work together to develop products that allow for more sophisticated tiering of cost-sharing. For example, no plan is currently capable of administering tiered ER copayments based on diagnosis, with the highest copayment being paid by individuals who come to the ER with a diagnosis that could be treated in a less intense setting. This would constitute a next phase in value-based benefit design development.

It is important to note the distinction between value-based benefit design, and designs that simply shift costs from employers to employees through increased copayments and the introduction of high deductible health plans. Research has found that shifting costs to employees can create financial barriers to receiving necessary care. For example, research has shown that copayment levels have a direct impact on whether certain patients fill their prescriptions, with the rate of filling prescriptions declining as copayment levels increase.[87] Research also suggests that high deductible plans can result in a reduction in the use of both needed and unneeded services.[88] These findings are of concern because patients, particularly those with chronic conditions who are non-compliant with standard treatment protocols, have higher medical costs than those who are compliant.[89]

Barriers to Designing and Offering Innovative Products

Value-based benefit design that increases an employee's out-of-pocket costs for use of certain providers or services brings fears that consumers will make choices based solely on economic factors without fully understanding the limits of their choice. These choices may lead to unhealthy behavior or choice that is not fully informed. Value-based benefit design must be coupled with clear communication of the full impact of choices presented in plan design options.

Cost Savings Potential

Fallon Community Health Plan offers each member at the point of enrollment a choice between its Direct Care network, which is a limited network, and its Select Care network, which is a broader network. Both networks cover similar geographic areas, but the Direct Care network has fewer providers. Providers are selected for the Direct Care network based on a combination of factors, including quality, utilization, geography, and practice structure. Fallon's premiums for its Direct Care network are 13% lower than the premiums for its Select Care network.

RAND modeled value-based insurance design focused on tying copayments to the expected benefit of a health care service. RAND estimated that implementing such insurance design could save as much as $1.2 billion over ten years. RAND's estimate includes Medicaid, where the strategy described here would exclude Medicaid and focus on commercial products.

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[87] Goldman DP, Joyce GF, and Karaca-Mandic P. "Varying pharmacy benefits with clinical status: the case of cholesterol-lowering therapy" *American Journal of Manage Care*, vol. 12, pages 21-28 (2006).
[88] Hibbard JH, Greene J, Tusler M. "Does Enrollment in a CDHP Stimulate Cost-Effective Utilization?" *Medical Care Research and Review*, Vol. 65, No 4, 437-449 (2008).
[89] In a presentation at the Pacific Business Group on Health's Pharmacy Symposium, April 2008, Jane Barlow, MD reported study results documenting the reduced costs of diabetics who are compliant with drug regimens.

RAND also modeled the impact of reference pricing for academic medical centers.[90] Potential savings based on varying premium and copayments depending on selection of provider is part of the valued based benefit design anticipated above, however, there is no assumption within the strategy as to which providers will ultimately fall within different premium or copayment tiers. In its analysis, RAND estimates a savings potential of up to $7.3 billion over ten years, when excluding Medicaid.

Conclusion

Value-based benefit design is an important cost containment strategy in that it provides employers and their employees with the ability to impact health care spending and reinforce the desire for a system that provides high-quality care at low cost.

Development of Health Resource Planning Capabilities

HCQCC has identified oversupply of health care services in Massachusetts as a driver of the overuse of health care services.[91] Overuse, in turn, has been identified as a significant factor in health care cost growth. We also are heavily reliant on hospital-based care, and lack an adequate supply of primary care providers. The payment reform strategies endorsed within this Roadmap are designed, in part, to specifically address these problems. However, HCQCC also recommends that the EOHHS, through the Division of Health Care Finance and Policy and the Department of Public Health, enhance its current analysis of health resources with required regular statewide assessments of the Commonwealth's health resource needs and informed recommendations related to planning, assessing, and allocating health care services based on the needs of Massachusetts residents. These planning activities should include a review of the impact of ACOs on the availability and use of health resources in the Commonwealth.

Having this enhanced responsibility within DHCFP and DPH will allow for leveraging of existing data and expertise. Additionally, it will allow EOHHS to leverage current resources in DHCFP and DPH to efficiently incorporate these activities. In addition, EOHHS will be in a strong position to quickly see potential unintended consequences of the Commonwealth's efforts towards global payments.

HCQCC envisions the following enhanced responsibilities: (1) health planning activities, including a conducting a comprehensive regular assessment of current and future health care service availability and need, and (2) enhanced Determination of Need (DoN) activities through increased use data identified in the health resource planning process and increased regulatory oversight of proposed projects. As part of its health planning activities, HCQCC recommends a comprehensive review of primary care services, the training necessary to provide them, and how best to provide primary care services. In addition, HCQCC suggests that health resource planning consider the potential of retail clinics to impact access across the Commonwealth.

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[90] RAND, pg. 79

[91] Supply-sensitive care is care in which there is unwarranted variation in frequency of use that typically is explained by supply. That is, where there is greater capacity for particular care or services, more of that care or services are supplied. According to the Dartmouth Atlas, supply-sensitive services include physician visits, diagnostic tests, hospitalizations and admissions to intensive care among patients with chronic illnesses. See *Supply-Sensitive Care*, A Dartmouth Atlas Project Topic Brief, Center for Evaluative Clinical Services, January 15, 2007.

Implementation Activities and Costs

The enhancement of health planning and DoN activities within EOHHS would require the following:

1. Legislation requiring EOHHS, through the DHCFP and DPH to enhance its health resource planning activities

2. Clear definition of vision and goals of the enhanced effort

3. Clear delineation of enhanced responsibilities

    a. Health Planning Activities

        i. Regular assessment and report to the state legislature and the HCQCC of current and future health care services availability and needs, including:

            1. Recommendations for regulatory changes to the DoN process in line with the findings of such assessment.
            2. Recommendations for creating incentives to develop supply in areas where lacking, including workforce development.

    b. Determination of Need

        i. Enhanced authority to review expansion requests for inpatient hospitals and outpatient hospital or ambulatory surgical centers, including:

            1. Expansion of authority to review expansions at a lower dollar threshold than is currently in place
            2. Continued review of special technologies

4. Identification of resource needs and ability to leverage current resources at DHCFP and DPH.

Why is Health Resource Planning Necessary?

Health resource planning will allow the state to strategically rationalize the health care system in order to contain health care cost growth. Today, health care supply is largely shaped by individual institutions without a strategic analysis of the health needs of our citizens. As Massachusetts embarks on a system-wide payment reform effort, it will be important for the Commonwealth to focus efforts on strategic health resource planning, both to prevent creation of excess supply of services, which has previously led to overuse, and to highlight areas of the health care system with limited access or availability and develop strategies to increase access to those services, including through workforce development.

In addition to a regular review of health resource needs of the state, an enhanced DoN process will allow for a more in-depth review of potential new or expanded facilities. Such enhanced review may include a strengthened ability to evaluate and compare the safety, efficacy, and cost

effectiveness of proposed new inpatient or outpatient facilities or expansions, leveraging the state's assessment of health resource needs.

Experience with Health Planning Authorities

A number of states undertake health resource planning, including Tennessee, Virginia, and Washington. The agencies charged with undertaking health resource planning vary both in design and breadth of authority.[92] Below are highlights related to the agencies responsibilities solely for health resource planning and DoN.

The Washington Office of Financial Management is charged with implementing the strategic health planning efforts directed by state legislation enacted in 2007. The legislation was enacted in response to a recommendation by the state's Blue Ribbon Commission that the state provide overarching guidance for health planning. The Strategic Health Planning Office is charged, in part, with serving "as a coordinating body for public and private efforts to … plan health facility and health service availability" and for developing "a health resources strategy establishing statewide health planning policies and goals related to the regional availability of health care facility and services, quality of care and cost of care."[93]

In Tennessee, the Division of Health Planning within the Department of Finance and Administration includes within its principles that "the state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care industry." In addition, the principles include that "the state should support the requirement and retention of a sufficient and quality health care workforce." The Division of Health Planning is currently developing a state health plan, which will, in part, revise and maintain the standards and criteria for Tennessee's Certificate of Need program.[94]

Virginia is one of a few states with regional health planning authorities. The state has five regional health care authorities. These authorities are non-profit organizations designated by the state to provide input on health resource decisions, including Certificate of Public Need (CoPN), as well as regional health planning information and expertise.[95] The authorities are funded through the state on a per capita basis. Their CoPN decisions are based on the state's Medical Facilities Plan, which provides standards to determine whether there is a public need for a project. The authorities may waive these standards in their deliberations in order to increase accessibility for residents to services.

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[92] For example, in Washington, the Office of Health Planning is charged with monitoring the overall quality and cost effectiveness of health care in the state. In Maryland, the same agency charged with health resource planning is also charged with developing a Health Information Exchange.

[93] Washington Office of Financial Management, Strategic Health Planning, www.ofm.wa.gov/shpo/planning/default.asp. See also E2SSB 5930 section 51 (1) and section 52 (1). For a summary of the Office's work to date and links to the products that have been developed see the Office's March 2009 progress report.

[94] Tennessee Department of Finance & Administration, Division of Health Planning, www.state.tn.us/healthplanning. The Division was created by 2002 Legislation (TCA Section 68-11-1625).

[95] See, for example, the Central Virginia Health Planning Authority at www.cvhpa.org. See also the Health Planning Agency of Southwest Virginia, Inc. at www hpaswv.org.

Potential Barriers to Effective Health Resource Planning

There are a number of potential barriers to implementing an effective Office of Health Resource Planning in Massachusetts as envisioned by HCQCC.

1. *Previous efforts at state health planning have failed*. Massachusetts had a broad health planning function in the 1970s that included a state Health Plan Development Agency, area Health System Agencies, and a DoN program. These functions were disbanded over time as a result of deregulation. The Massachusetts programs, as many similar programs across states, were seen as ineffective. Given the focus today on cost containment and payment reform, however, HCQCC believes that the time is ripe to reintroduce health resource planning to the Commonwealth. Specifically, HCQCC believes that based on a greater understanding today of how over- and under-supply of services lead to unnecessary health care costs, an enhanced role for health resource planning at EOHHS should include the ability to:

    a. produce timely data and reports on availability of services;
    b. tie findings from reports to recommendations for initiatives to address the reports' findings, and
    c. consider need as part of DoN determinations for expansion and creation of facilities.

2. *Provider resistance*. Providers are likely to oppose greater governmental intervention into expansions of facilities and technologies. Their opposition is likely to be both on the grounds of the additional administrative burdens placed on health care providers to obtain approvals of expansion requests and an overall dislike of government involvement in the area.

Cost Savings Potential

There is limited evidence that DoN programs by themselves lead to cost containment. See *Containing Health Care Spending in Massachusetts: An Analysis of Options, Option #14 Extend Determination of Need Program*, pages 165-171, RAND Health, August 2009. Typically, however, these DoN programs have limited regulatory authority and only require health care institutions to seek approval prior to making substantial capital expenditures. The DoN process does not proactively look at current or future health resource needs for a given population. The RAND analysis does not study the potential for cost savings based on a more proactive health resource planning approach that encompasses both DoN and careful analysis and assessment of health resource needs.

Similar Pending Legislation

Senate Bill 565, An Act Relative to Strengthening the DoN Program has been filed by Senator Moore. While HCQCC commends the legislation, HCQCC believes that the legislation falls short by seemingly limiting the reach of the statewide health planning initiative to an assessment of inpatient and outpatient facility needs, and not looking at the health care system as a whole.

Conclusion

An enhanced effort for health resource planning is an important and complimentary tool to the state's payment reform efforts. Health resource planning will produce analysis, assessments, and reports detailing current and future health care needs. Enhanced health resource planning may work in concert with other cost containment strategies to reduce the amount of overuse of

medical care that goes on in Massachusetts. More importantly, perhaps, enhanced resource planning may identify and plan for health care supply shortages that contribute to unnecessary health care costs.

Enactment of Medical Liability Reform

The practice of defensive medicine, whereby doctors provide unnecessary or low-value service out of fear of legal liability, is another source of overuse in the health care system.[96] According to a recent report by the Massachusetts Medical Society, the practice of defensive medicine costs $1.4 billion per year in the Commonwealth.[97] In addition, the Congressional Budget Office (CBO) just released a revised estimate of savings that can be expected through malpractice reform that supports the notion that malpractice reform will have a significant impact on reducing the practice of defensive medicine.[98] HCQCC believes that an important element of a redesigned health system is providing appropriate protections to providers to help reduce the practice of defensive medicine. We therefore recommend that the state legislature enact appropriate malpractice reform that will help lessen this phenomenon.

Peer review, through which providers compare their work for both unwarranted variations in practice and potential sources of error or waste, also is proven effective in reducing overuse of health care services.[99] HCQCC therefore recommends adoption by the state legislature of a peer review statute that would allow for greater information-sharing between providers, regardless of where they work, to promote lessons learned and best practices without the fear that the results of such learning could be used against them in a malpractice case.

Medical Liability Reform Strategy

HCQCC believes that the time has come to enact significant medical liability reform in Massachusetts and urges the state legislature to enact reform in its 2010 session with a clearly defined goal of reducing the practice of defensive medicine, contributing to the overuse of medical services.

Given the wealth of expertise on the issue of medical malpractice in Massachusetts, HCQCC does not presume to recommend the specific legislative language to be enacted or whether there is the need for a special commission on medical malpractice to reach consensus. HCQCC does,

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[96] Investigation of Defensive Medicine in Massachusetts," Massachusetts Medical Society, November, 2008. There have been a number of surveys of physicians in other states that also suggest a strong link between fear of malpractice and the practice of defensive medicine. See, for example, Studdert, David M. et al.; Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment, *Journal of the American Medical Association*, June 2005, Vol. 293, pages 2609-2617; which conducted a study of physicians in Pennsylvania.

[97] "Investigation of Defensive Medicine in Massachusetts," Massachusetts Medical Society, November, 2008, Waltham, MA.

[98] October 9, 2009 Letter from CBO Director Douglas Elmendorf to Senator Orrin Hatch; accessed at www.cbo.gov on October 13, 2009.

[99] See, e.g., Ineke Welschen, Marijke M Kuyvenhoven, Arno W Hoes, and Theo J M Verheij, Effectiveness of a multiple intervention to reduce antibiotic prescribing for respiratory tract symptoms in primary care: randomized controlled trial, BMJ, Aug 2004; 329: 431.

however, urge the state legislature and the Patrick administration to consider current opportunities through AHRQ grant funding to inform medical liability reform.[100]

The Current Malpractice Laws in the Commonwealth

Pursuant to Chapter 305, the Division of Insurance (DOI) completed and submitted a study of medical malpractice in Massachusetts to the state legislature in December 2008.[101] The DOI report provides a detailed description of who provides malpractice coverage in the state, how much the premiums have cost and how they compare to other states, and potential options to decrease malpractice premiums.[102]

Under current Massachusetts law, medical malpractice claims are reviewed for merit by a tribunal.[103] Individuals have three years in which to file a malpractice lawsuit.[104] When one or more health care professionals is named in a lawsuit, each provider is jointly and severally liable for the full amount of damages.[105] This is particularly problematic for physicians where non-profit hospitals have limited liability based on charitable immunity to $20,000 per action.[106] A hospital or its staff could be primarily responsible for a bad outcome, but the physician's malpractice insurance still is responsible for payment of most of the malpractice payout. Pain and suffering damages are limited to $500,000.[107]

Why is Medical Liability Reform Necessary?

Like other states, medical malpractice is often on the legislative agenda in Massachusetts.

Goals of Medical Liability Reform

While this report is focused on efforts to contain costs, it is important to put this strategy within a larger context of improving quality and consumer engagement. As described below, the goals of medical liability reform encompass more than cost containment. Specifically, they include:

- putting patient safety first, and working to reduce preventable injuries;
- reducing pressure on providers to practice defensive medicine;
- fostering better communications between doctors and their patients;
- stimulating the discovery of incident, disclosure and apology where appropriate;
- ensuring that patients are compensated in a fair and timely manner for medical injuries;
- placing appropriate accountability on organizations and individuals;
- reducing the incidence of frivolous lawsuits;

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[100] The current AHRQ grants may be viewed at www.ahrq.gov/fund/rfaHS1022 htm and www.ahrq.gov/fund/rfaHS1021.htm.
[101] See Section 65 of Chapter 305 of the Acts of 2008.
[102] The report, Medical Malpractice Insurance in the Massachusetts Market, was submitted to the legislature on December 31, 2008 and is available on DOI's website at www.mass.gov/doi.
[103] See M.G.L. c. 231, sec. 60B.
[104] See M.G.L. c. 260, sec. 4 and M.G.L. c. 231, sec. 60D.
[105] See M.G.L. c. 231B, sec. 2.
[106] See M.G.L. c.231, sec 85K.
[107] See M.G.L. c. 231, sec. 60H. According to testimony received by DOI as part of its study, 21 states have lower caps on pain and suffering damages; the lowest cap is $250,000. See Medical Malpractice Insurance in the Massachusetts Market, page 23.

- reducing liability premiums; and
- increase the ability to share best practices and lessons learned across organizations.

Increasing Malpractice Premiums
Malpractice premiums have been increasing at a pace similar to as health insurance premiums. Malpractice premiums grew an average of 15% between 2000 and 2002.[108] Increases varied by specialty, with obstetricians and gynecologists seeing a 22% increase and internists and general surgeons seeing a 33% increase.[109] The Congressional Budget Office's 2004 report on medical malpractice suggested that premium growth was due to a combination of increased costs related to malpractice claims combined with reduced malpractice insurer investment income.[110]

Despite these large increases in premiums and the potential to slow or stop their growth, malpractice premiums account for less than 2% of the overall spending on health care.[111] A May 2008 article in *Health Affairs* suggested that there is not a medical malpractice crisis in Massachusetts. Although Massachusetts' malpractice payouts are near the top of the range of recoveries, the state's malpractice premiums are comparable to other states. Thus, medical malpractice reform will only account directly for a small sliver of cost containment.

Defensive Medicine
However, physicians have long argued that the added costs are not in the malpractice premiums, but in the ordering and delivery of unnecessary services due to the fear of a malpractice suit. According to a November 2008 report conducted for the Massachusetts Medical Society (MMS), most of the state's doctors practice defensive medicine due to fear of malpractice lawsuits.[112] The report further concludes that the practice of defensive medicine costs more than $1.4 billion per year.[113] The report is based on a survey of Massachusetts physicians and links defensive medicine with Medicare cost data.

The practice of defensive medicine, whether or not it is as widespread as the MMS-sponsored survey suggests, leads to an overuse of clinical services by patients and potential harm due to unnecessary interaction with the health care system. A change to malpractice laws, particularly when coupled with payment reform and evidence-based coverage strategies, could affect a cultural change that provides physicians and other providers with the tools and confidence to practice with greater efficiency.

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[108] Limiting Tort Liability for Medical Malpractice, Congressional Budget Office, January 8, 2004.
[109] Ibid.
[110] Given the weak state of the economy, insurance companies are likely to have reduced assets again this year due to loss of value in investments.
[111] Ibid.
[112] "Investigation of Defensive Medicine in Massachusetts," Massachusetts Medical Society, November, 2008. There have been a number of surveys of physicians in other states that also suggest a strong link between fear of malpractice and the practice of defensive medicine. See, for example, Studdert, David M. et al.; Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment, *Journal of the American Medical Association*, June 2005, Vol. 293, pages 2609-2617; which conducted a study of physicians in Pennsylvania.
[113] Ibid. The MMS report, done in partnership with the University of Connecticut, was the first to quantify the potential cost of the practice of defensive medicine. See Goodnough, Kristina, Study shows defensive medicine widespread, The UConn Advance, University of Connecticut, February 23, 2009.

Barriers to Malpractice Reform

There have been several unsuccessful efforts to reform Massachusetts malpractice laws in the past. An active plaintiff's bar does not favor malpractice reform, particularly caps on malpractice awards.

Cost Savings Potential

As noted above, there is the potential for small cost containment through reduction in the growth of malpractice premiums. There is greater potential for cost containment if, as noted in the MMS report, physicians stop practicing defensive medicine, resulting in the reduction of overuse of services. In its most recent analysis, the CBO estimated, for the first time, significant savings in the form of reduced defensive medicine through malpractice reform.[114] This is consistent with findings from physician surveys that link fear of malpractice suits to the practice of defensive medicine and studies which show savings in health care costs where medical malpractice reforms have been enacted.[115] Prior to its most recent estimate, the CBO had previously found that malpractice reform did not reduce medical spending in Medicare.[116] In its subsequent April 2006 report, the CBO noted that although there is clear evidence that tort reform has the impact of reducing malpractice awards and reducing malpractice premiums, it has had an inconsistent impact on spending for health care services.[117]

Since the passage of malpractice reform in Michigan that includes an apology, offer of fair compensation, and a timely notice provision, the University of Michigan Health System (UMHS) has seen reduced cost associated with litigation, including the ability to significantly reduce its insurance reserves resulting in the ability to reinvest a portion of those dollars in patient safety.[118] In its analysis of cost containment strategies for the DHCFP, RAND reviewed the potential of cost savings related to malpractice reform. Its analysis concludes that there is limited potential for cost savings associated directly with reduce malpractice premiums. With respect to cost savings related to reduced practice of defensive medicine, RAND's literature review found limited empirical evidence of the practice of defensive medicine.[119]

Conclusion

Despite the fact that there appear to be limited short-term savings associated with medical malpractice reform, HCQCC endorses malpractice reform as one of the tools that can and should be utilized as part of an overall system effort to affect a cultural change that leads to reduced overuse of services and improved patient care.

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[114] October 9, 2009 Letter from CBO Director Douglas Elmendorf to Senator Orrin Hatch; accessed at www.cbo.gov on October 13, 2009.
[115] Lisa Dubay, Robert Kaestner, and Timothy Waidmann, "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics*, vol. 18 (August 1999), pp. 518-519.
[116] Limiting Tort Liability for Medical Malpractice, Congressional Budget Office, January 8, 2004.
[117] The Congressional Budget Office, Medical Malpractice Tort Limits and Health Care Spending, April 2006.
[118] See Richard C. Boothman, Amy C. Blackwell, Darrell A. Campbell, Jr., Elaine Commiskey, and Susan Anderson, *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, J. HEALTH & LIFE SCI. L., January 2009 at 125.
[119] Christine E. Eibner, Hussey PS, Ridgely MS, and McGlynn EA. "Controlling Health Care Spending in Massachusetts: An Analysis of Options," Option #21 Change Laws Related to the Non-Economic Damages Cap and Expert Witnesses, The RAND Corporation, August 2009, pages 227-228.

Peer Review Strategy

In addition to undertaking an effort to reform the malpractice system, HCQCC urges the state legislature to enact statutory language that expands current peer review protections to allow for peer review across provider systems. This will allow for greater variation analysis across provider systems and increased learning from potential medical errors with an ultimate goal of increased patient safety. This proposed expansion of the peer review statute does not in anyway shield an individual provider or institution against malpractice litigation.

The key elements to be included in expanded peer review legislation are:

- the formation or designation of one or more umbrella organizations that can conduct peer review across systems for educational and training purposes.
- data developed for use by an umbrella organization functioning as a peer review body is not admissible as evidence in malpractice or other litigation; records of patient care and treatment remain admissible.

Currently pending in the state legislature are two identical bills (House 2073 and Senate 834) that would expand existing peer review protections to any individual or group that performs the duties of a medical peer review committee. The pending legislation reads as follows:

> Section 1. Chapter 111 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by inserting at the end of section 204 the following:

(f) The provisions of this section shall apply to any committee formed by an individual or group to perform the duties or functions of medical peer review, notwithstanding the fact that the formation of the committee is not required by law or regulation or that the individual or group is not solely affiliated with a public hospital or licensed hospital or nursing home or health maintenance organization.

Why is an Expansion of the Peer Review Statute Necessary?

Section 203 and 204 of Chapter 111 of the General Laws address medical peer review and the confidentiality of such proceedings. While the existing statutory language is intended to "promote candor and confidentiality "in the peer review process and "foster aggressive critiquing of medical care by the provider's peers,"[120] the current statutes only extend peer review protections across providers and systems to improve patient care in all settings and systems. The Commonwealth does not currently have a specific statute relating to peer review, but there is some ability to do peer review on an aggregate basis through a combination of information reported to the Department of Public Health (DPH) and the Board of Registration in Medicine (BORIM). The two entities are currently working together to determine how, within the confines of their current responsibilities, they may be able to broaden learning from adverse events that are reported to DPH and BORIM.

Specifically, the pending legislation would allow for protected peer review across provider systems, including hospitals to engage in peer review through an entire system and physician

[120] Vranos v. Franklin Med. Ctr., 448 Mass. 425, 433 (2007), quoting Pardo v. General Hosp. Corp, 446 Mass. 1, 11 (2006).

group practices across its members. Moreover, the language would allow for any provider safety organization (PSO) to engage in peer review activities for the purposes of education and training with the requisite discovery protections.

Barriers to Expanding Peer Review

An expansion to the peer review statute may be opposed by the trial bar and patients that fear that such an expansion would limit discoverable data. However, all underlying medical records and data are discoverable and admissible in litigation. Only products specifically created for use before a peer review organization would be exempt from discovery.

Cost Savings Potential

RAND did not consider peer review in its review of potential cost containment strategies. While HCQCC therefore attributes no specific cost containment to the strategy, HCQCC believes that enactment of such a strategy will improve overall patient safety, increase sharing of lessons learned across providers and systems, and lead to a reduction in the overuse and misuse of medical services.

Conclusion

The expansion of the peer review protection in the Commonwealth will allow for greater education and training of providers across the health care system on potential medical errors and lessons learned from those experiences. While not in and of itself a strategy that will contain costs, an expanded peer review statute will allow for improved patient safety and reduced overuse or misuse of medical services.

Administrative Simplification

Most health care spending pays for the direct provision of care. However, administrative costs, in terms of both costs incurred by insurers to administer coverage and costs incurred by providers and patients in navigating the system and complying with rules, are significant.[121] Chapter 305 of the Acts of 2008 included a number of efforts to reduce administrative complexity in health care, including DOI's effort related to uniform billing requirements by payers. Further, a number of significant voluntary efforts are underway, such as the Patrick administration's Healthy Mass Compact and efforts of the Employers Action Coalition for Health (EACH) to reduce administrative costs related to eligibility verification for both commercial and public payers.[122] HCQCC commends the work to date to reduce administrative burdens within the health care system and recognizes that it is difficult to make progress and remain committed to these projects given limited state resources. Despite limited state resources, a continued focus on efforts to reduce administrative complexity is imperative. This work demonstrates the state's commitment to do its part to reduce health care costs in the Commonwealth by easing regulatory burdens on payers and providers wherever possible, and has the potential to remove significant costs from the system.

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[121] According to a September 2008 report commissioned by the Massachusetts Division of Insurance, insurers utilize 10.9% of each premium dollar for administrative expenses (excluding investment expenses). See "Analysis of Administrative Expenses for Health Insurance Companies in Massachusetts," Massachusetts Division of Insurance, prepared by Oliver Wyman, September 2008.

[122] For more information on administrative simplification efforts, see Chapter Four.

Consumer Engagement Efforts

HCQCC recommends a multi-faceted campaign to increase consumer engagement in health care through increased awareness of the health care system and specific treatment options for individual care. Specifically, HCQCC recommends leveraging the work of organizations such as the Partnership for Healthcare Excellence, which are continuing to embark on public education campaigns and on-the-ground outreach in target markets with documented success. To compliment these public education campaigns, HCQCC urges additional consumer engagement through models such as Shared Decision-Making and the Patient-Centered Medical Home, which have been shown effective as a means of shifting consumer demand from low-value to high-value care and improving quality by better reflecting patient preferences for care.[123] Such consumer engagement is a critical underpinning of a redesigned health care system.

As described in Chapter Four, the Executive Office of Health and Human Services (EOHHS) is facilitating a Patient-Centered Medical Home Initiative (PCMHI) is underway in the Commonwealth. The PCMHI effort involves all of the major private payers and MassHealth, representatives of the primary care community, purchasers, consumer advocates, and researchers. Beginning in June 2009, an advisory council consisting of over 50 individuals began an intensive planning process with a goal of implementation during 2010.

Why is Consumer Engagement Necessary?

Providing consumers with greater information prior to their interaction with the health care system associated with their particular disease or illness will provide for greater familiarity with the system at the time of an adverse event, and allow patients greater understanding of the importance of their own involvement in their care. Patient activation and empowerment methods have been shown to lead to better health outcomes, reduced disparities, and better satisfaction with one's care, as well as reduced costs.[124]

Barriers to Consumer Engagement

It is often difficult to engage consumers on health care, despite their concern of its high costs, until they are specifically impacted by an illness or acute event requiring care. Even then, as patients, many individuals believe that the provider knows best and that their engagement won't make a real difference in their care. Further, many patients lack the confidence to question a provider's plan of treatment.

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[123] See Annette M. O'Connor, John E. Wennberg, France Legare, Hilary A. Llewellyn-Thomas, Benjamin W. Moulton, Karen R. Sepucha, Andrea G. Sodano, and Jaime S. King. "Toward The 'Tipping Point': Decision Aids And Informed Patient Choice." *Health Affairs*, May/June 2007; 26(3): 716-725. See also, John E. Wennberg, Annette M. O'Connor, E. Dale Collins, and James N. Weinstein. "Extending The P4P Agenda, Part 1: How Medicare Can Improve Patient Decision Making And Reduce Unnecessary Care," *Health Affairs*, November/December 2007; 26(6): 1564-1574.

[124] See, e.g., Stafield B. Shi L., and Macinko, J., Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. "Improving chronic illness care: translating evidence into action," Health Affairs, 2001 20:64-78; see also, A.C. Beal, M.M. Doty, S.E. Hernandez, K.K. Shea, and K. Davis, "Closing the Divide: How Medical Homes Promote Equity in Healthcare: Results From The Commonwealth Fund 2006 Healthcare Quality Survey," The Commonwealth Fund, June 2007.

Cost Savings Potential

RAND did not consider consumer engagement in its review of potential opportunities.[125] However, a consumer engagement strategy may increase the effectiveness of a number of other strategies included in the Roadmap, including payment reform and use of evidence-based coverage.

Conclusion

Consumer engagement in health care generally, and an individual patient's involvement and engagement in his or her own care are important components of a redesigned health care system. Today, too little of the health care system is patient-centered. This strategy will assist patients in playing a greater role in their care and in impacting the system as a whole.

Promoting Good Health

The medical care costs of people with chronic diseases account for more than 75 percent of the nation's medical care costs.[126] Many chronic diseases arise and worsen because of a variety of factors, including environmental conditions, socio-economic factors, and behaviors of the individuals afflicted. These factors account for at least 900,000 deaths annually in the United States About half of these are related to diet or physical activity, and the other half are primarily due to decisions regarding tobacco use. Of these 900,000 deaths, about 40 percent are "early deaths," that is, they occur at younger ages than would normally be expected. Taken together, the complex factors that result in unhealthy behaviors represent the single greatest domain of influence on the health of the population.[127]

In Massachusetts, while we have made great strides in reducing rates of smoking, trends are not as positive in other areas.[128] Obesity incidence almost doubled in Massachusetts between 1995 and 2008, growing from 11.7 to 22.5 percent of the population. Parallel to the increased prevalence of obesity has been growth in the prevalence of diabetes. Diabetes in the Massachusetts population grew 29 percent in a recent four-year period.

HCQCC endorses a multi-part strategy to promote increases in healthy behaviors across the state population in order to reduce incidence and growth in severity of the chronic conditions that account for most health care spending in the Commonwealth. This effort should be spearheaded by the Department of Public Health, but shaped and implemented by a broad array of entities. Its component elements should be:

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[125] RAND did model potential savings related to creating medical homes to enhance primary care. See RAND, pg. 91.

[126] Chronic Disease Overview, Centers for Disease Control and Prevention, www.cdc.gov/nccdphp/overview.htm, accessed August 4, 2009.

[127] McGinnis JM et. al., "The Case For More Active Attention to Health Promotion," *Health Affairs*, 21(2), 78-93, March/April 2002.

[128] apps nccd.cdc.gov/brfss/display.asp?cat=TU&yr=2008&qkey=4396&state=MA, accessed August 4, 2009.

#1: Community Engagement

As part of its *Mass In Motion* program to prevent obesity and to reduce chronic disease, DPH initiated a community grant program and created a website (www.mass.gov/massinmotion/) to provide tools to communities to implement activities such as:[129]

- Changing school food service requirements;
- Changing school curricula;
- Providing after-school programs;
- Reaching out to parents, city employees, and communities;
- Working with restaurants to increase healthy menu options;
- Developing "walkability" and safe routes to school;
- Working with school nurses and pediatricians; and
- Developing farmers markets and community/school gardens.

A model Massachusetts community has been Somerville, which began *Shape Up Somerville: Eat Smart. Play Hard* using funds from a CDC grant (2002-2005).[130] This program focused on obesity reduction in elementary school-age children. *Shape Up Somerville*, as it is now known, has since expanded to address a broader community population and all of the core activities of Mass in Motion listed above.

HCQCC recommends that DPH coordinate efforts to fund similar efforts in other Massachusetts communities, but with a focus that can expand to address smoking, substance abuse, and other chronic conditions in addition to obesity. These funds should be spent helping to organize community-based changes relating to areas such as transportation policy, recreation activities, school food policy, restaurant meal options, and behavioral change incentives.

Acknowledging the recent budget cuts experienced by DPH, HCQCC recommends supplementing any available DPH Mass in Motion grant funds with those available from the CDC through its Healthy Communities Program[131] (which is currently funding a community-based effort in New Bedford), the continuing support of Massachusetts organizations and foundations currently committed to supporting *Mass in Motion* for two years,[132] and grant funds available from additional organizations (e.g., the Massachusetts Municipal Association) and foundations.

#2: Employer Engagement

According to the National Compensation Survey, approximately 28 percent of private sector workers in the United States had access to employer-sponsored wellness programs in 2008.[133] HCQCC commends DPH for its workplace wellness initiative, including its Worksite Wellness

[129] www.somervillema.gov/Division.cfm?orgunit=SUS, accessed August 4, 2009.
[130] http://nutrition.tufts.edu/1174562918285/Nutrition-Page-nl2w_1179115086248.html, accessed August 4, 2009.
[131] www.cdc.gov/healthycommunitiesprogram/communities/achieve.htm, accessed August 4, 2009.
[132] These organizations include Blue Cross Blue Shield of Massachusetts, The Blue Cross Blue Shield Foundation, The Boston Foundation, The Harvard Pilgrim Health Foundation, The MetroWest Health Foundation, and The Tufts Health Care Foundation.
[133] www.bls.gov/opub/cwc/cm20090416ar01p1.htm, accessed August 4, 2009.

Program Toolkit available online through *Mass in Motion*.[134] HCQCC recommends that DPH strengthen such efforts by collaborating with employer organizations in the Commonwealth to increase the prevalence of such programs in a manner that involves health insurers.

#3: Evidence-Based Regulatory Interventions

Public health regulation can make a big impact on healthy behaviors. HCQCC supports DPH's use of evidence-based interventions, such as nutritional menu labeling and school-based body mass index measurement, which can contribute to healthy behaviors. HCQCC encourages DPH to consider and propose additional strategies.[135]

#4: Public Health Campaigns

Recognizing the success of previous public health campaigns, HCQCC urges restarting and maintaining such campaigns, to keep the messages at the forefront. Among the topics to address should be preventing or reducing smoking, substance abuse, poor eating habits, and lack of physical activity. Such campaigns should target children and adolescents as well as other populations at risk.

Implementation Activities and Costs

The promotion of healthy behaviors will entail the following:

1. Expansion of *Mass in Motion* so that it can result in grants to more communities than the program is able to support today. This may entail some additional project staff at DPH, and additional grants to communities. Expansion will require concerted efforts to expand and sustain program funding;
2. Complementary efforts at community organizing around health. While Mass in Motion funding is an important support, many communities already have non-profit and volunteer organizations whose missions and activities and activities are consistent with the aim of promoting healthy behaviors. A relatively modest investment in community organizing by DPH could leverage these existing resources;
3. A concerted effort to organize, energize and engage Massachusetts employers in taking steps to support healthy behaviors. This should be done in coordination with other Roadmap strategies affecting employers, (e.g., health benefit design innovation, payment reform);
4. Continued targeted, evidence-based regulatory activity by DPH; and
5. Continued public health messages about the potential dangers of unhealthy behaviors.

Why Is Promoting Good Health Necessary?

The medical care costs of people with chronic diseases account for more than 75% of the nation's medical care costs. These same diseases also account for about 70% of all deaths.[136]

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[134] www mass.gov/Eeohhs2/docs/dph/mass_in_motion/worksite_toolkit.pdf, accessed August 4, 2009.

[135] For example, the Public Health Council has previously endorsed a tax on sugar-sweetened drinks. Likewise, the Commonwealth Fund has advocated the creation of such a tax and modeled savings that would result from such a strategy. See "Bending the Curve," The Commonwealth Fund Commission on a High Performance Health System, December 2007.

[136] Chronic Disease Overview, Centers for Disease Control and Prevention, www.cdc.gov/nccdphp/overview.htm, accessed August 4, 2009.

Many of the chronic diseases arise and worsen because of a variety of factors, including environmental conditions, socio-economic factors, and behaviors of the individuals afflicted.

These factors account for at least 900,000 deaths annually in the United States About half of these are due to diet or physical activity, and the other half are primarily due to tobacco use. Of these 900,000 deaths, about 40% are "early deaths," that is, they occur at younger ages than would normally be expected. Taken together, these factors represent the single greatest domain of influence on the health of the population.[137] One national study estimated that between a quarter and a third of the growth in health spending between 1987 and 2002 was a result of modifiable risk factors.[138]

Massachusetts has made a concerted effort to reducing smoking in the population, spearheaded by a longstanding Department of Public Health effort. That effort has dropped smoking prevalence among adults by over 25% since 1995.[139] Massachusetts ranks ninth in the country now, with 16% of the adult population and 18% of the teen population self-identifying itself as smokers.[140] In turn, reduced smoking led to a reduction in health care spending. A 2000 study of Massachusetts' early tobacco prevention program (before its funding was cut) found that after only a few years it was annually saving well over two dollars in reduced smoking-caused health care costs for every single dollar it received in state funding.[141] Earlier, state officials announced that the program had reaped enormous savings by reducing smoking among pregnant women, which places costly demands on state health care systems by causing low birth-weight babies, other pregnancy complications, and a range of early childhood health and development issues.[142] Trends are not as positive in other areas:[143]

- Obesity incidence almost doubled in Massachusetts between 1995 and 2008, growing from 11.7% to 22.5% of the population. 59.1% of the Massachusetts population was either overweight or obese in 2008.
- Parallel to the increased prevalence in obesity, and undoubtedly influenced by it, has been growth in the prevalence of diabetes. Diabetes in the Massachusetts population grew 29% in a recent four-year period, increasing from 5.6% to 7.2%.

Increasing and special national focus has been directed to the growing prevalence of obesity. Obesity's growth has been attributed to declining rates of physical activity among children and

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[137] McGinnis JM et. al., "The Case For More Active Attention to Health Promotion," *Health Affairs*, 21(2), 78-93, March/April 2002.
[138] Thorpe KE et. al. "The Impact of Obesity on Rising Medical Spending," *Health Affairs*, October 25, 2005.
[139] http://apps nccd.cdc.gov/brfss/display.asp?cat=TU&yr=2008&qkey=4396&state=MA, accessed August 4, 2009.
[140] www.cdc.gov/NCCdphp/states/pdf/massachusetts.pdf, accessed August 4, 2009
[141] Harris, J. E., "Status Report on the Massachusetts Tobacco Control Campaign, with a Preliminary Calculation of the Impact of the Campaign on Total Health Care Spending in Massachusetts," 2000.
[142] Connolly, W., Director, Massachusetts Tobacco Control Program, Testimony, Joint Hearing of Pennsylvania House of Representatives Committee on Health & Human Services and Senate Committee on Public Health & Welfare, June 22, 1999. Miller, P, et al., "Birth and First-Year Costs for Mothers and Infants Attributable to Maternal Smoking," *Nicotine & Tobacco Research* 3(1): 25-35, February 2001 [avg. cost per smoking-affected birth: $1,142]; Campaign for Tobacco-Free Kids (TFK), Fact Sheet, *Harm Caused by Pregnant Women Smoking or Being Exposed to Secondhand Smoke*, http://tobaccofreekids.org/research/factsheets/pdf/0007.pdf
[143] apps nccd.cdc.gov/brfss/display.asp?cat=TU&yr=2008&qkey=4396&state=MA, accessed August 4, 2009.

adults, and poor nutrition. A recent study of national costs attributed 9.1 percent of total United States medical expenditures in 2006 to obesity (body mass index greater than 30). The authors also found that across all payers, per capita medical spending for the obese is $1,429 higher per year, or roughly 42 percent higher, than for someone of normal weight.[144]

Many Massachusetts residents exhibit poor behaviors in areas shown to reduce the prevalence and exacerbation of chronic illness. In 2006 or 2007:

- 73% of adults consumed fewer than five fruits and vegetables per day;
- 40% of high school students did not attend physical education classes;
- 49% of adults were not engaged in sufficient moderate or vigorous physical activity;
- 25% of male adults reported binge drinking – one of the highest rates in the country;
- 15% of women age 40 or older, reported not having had a mammogram within the last two years;
- 34% of adults age 50 or older reported never having had a sigmoidoscopy or colonoscopy, and
- 72% of adults age 50 or older reported not having had a fecal occult blood test within the past two years.[145,146]

Finally, in addition to lifestyle factors and seeking preventive care, consumers also make decisions about adhering to medical treatment regimens. The World Health Organization reported that only about 50% of people follow physician orders regarding prescription drugs, with the rate lower for certain conditions. In addition, studies have shown that 20-30% of patients completely quit taking prescribed medications within a year of starting.[147] High-income, educated people are as likely to be non-compliant as those who are less wealthy and less educated.[148] The problem of non-adherence applies not only to prescribed medication, but affects all prescribed medical treatment.

Barriers to Promoting Good Health

The greatest challenge to promoting good health is enabling lifestyle changes by communities, employers, and individuals. HCQCC believes that this recommended approach, that uses communities and employers as a leverage point, may prove more successful than one that is solely directed at consumers. It is clear, however, given the deteriorating health status profile of many Massachusetts residents that this strategy, while necessary, is not assured of success.

Cost Savings Potential

Despite the clear attribution of high health care costs to unhealthy behaviors, there is little available evidence on the cost savings attributable to the community-oriented approach to healthy behaviors recommended by HCQCC. In its report to the Division of Health Care Finance

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[144] Eric A. Finkelstein, Trogdon JG, Cohen JW, and Dietz W. "Annual Medical Spending Attributable To Obesity: Payer- And Service-Specific Estimates," *Health Affairs*, 28, no. 5 (2009): w822-w831.
[145] www.cdc.gov/NCCdphp/states/pdf/massachusetts.pdf, accessed August 4, 2009.
[146] www niaaa.nih.gov/Resources/DatabaseResources/QuickFacts/Adults/brfss03 htm, accessed August 4, 2009.
[147] Amy Dockser Marcus, "The Real Drug Problem: Forgetting to Take Them," *The Wall Street Journal*, October 21, 2003.
[148] Rubin R. "Doctors baffled by patients not taking prescriptions," *USA Today*, March 29, 2007.

and Policy, RAND reported that "Some community-based primary prevention interventions (e.g., raising taxes on cigarettes, Shape Up Somerville) may be effective and cost-saving. Most of the community interventions are relatively small demonstration projects that have not been replicated on a large scale."[149] What is clear, however, is that with the exception of tobacco use, where progress has been made, existing interventions to promote healthy behaviors are not currently succeeding.

There is more evidence with regard to employer-based wellness programs, but the research evidence is often not of a very high standard, and is insufficient to project savings.[150] RAND reported that:

> "Systematic reviews of the literature suggest that certain types of workplace health-promotion programs, when carefully targeted to high-risk individuals, are likely to produce a positive return on investment. However, some of this return involves nonmedical costs (e.g., reduced employee absenteeism) that would not directly affect premium prices."[151]

Still there are many studies documenting the cost savings attributable to employer programs,[152] and even more published case studies.

Conclusion

Research has shown that as an individual's overall health risk decreases or increases, their medical claims costs decrease or increase accordingly.[153] Unfortunately, the health risks of Americans have increased in many ways in recent years due to many factors, of which diet and sedentary lifestyle may be the most serious.

The challenge of improving health behaviors may be the greatest of all those considered by HCQCC, because a) it requires strategies that extend far outside of the health care system, and b) there has been limited recent evidence of success. HCQCC nevertheless believes that because promoting good health will have such a significant impact on health care costs – not to mention productivity and well being – it is incumbent upon the Commonwealth to take efforts to address the challenge.

Widespread Adoption of the Sciences of System Design and Engineering By Health Care Providers

In order to successfully implement this Roadmap, significant system redesign focused on both process and infrastructure improvements is necessary. These changes will impact the way many

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[149] Christine E. Eibner, Hussey PS, Ridgely MS, and McGlynn EA. "Controlling Health Care Spending in Massachusetts: An Analysis of Options," The RAND Corporation, August 2009.
[150] Kenneth R. Pelletier. "A Review and Analysis of the Clinical and Cost-Effectiveness Studies of Comprehensive Health Promotion and Disease Management Programs at the Worksite: Update VI 2004-2008," *Journal of Occupational and Environmental Medicine*, 51(7);822-837, July 2009.
[151] Op. cit., Eibner.
[152] Barbara L. Naydeck, Pearson JA., Ozminkowski, RJ, Day BT, and Goetzel RZ. "The Impact of the Highmark Employee Wellness Program on 4-Year Costs" *Journal of Occupational and Environmental Medicine.* 50(2):146-156, February 2008.
[153] D. W. Edington, Yen LT, and Witting P. "The Financial Impact of Changes in Personal Health Practices," *Journal of Occupational and Environmental Medicine,* Nov. 1997 39(11):1037–46.

providers practice medicine today. System redesign needs to be embraced by individual providers and organizations as well as across the health care community and its stakeholders. System redesign will require significant support to ensure that it is incorporated into every day practice of providers and truly improves the quality of health care provided. HCQCC recommends that the EOHHS take a leadership role to convene the health care community and large employers (including colleges and universities) to develop expertise and spread best practices among employers, providers, state agencies and educational institutions to support health care system redesign.

EOHHS and its collaborators should convene periodic educational forums that allow stakeholders to learn and share experience from system redesign efforts. Forums will showcase elements of the sciences of system redesign, including both process and infrastructure improvements, and presenters should be both from Massachusetts and across the country. In addition to the educational forums, EOHHS should work with willing stakeholders, including large employers and universities, to also support research projects, cross industry partnerships, improvement collaboratives and other shared projects that will reinforce the other recommended strategies to redesign the health care system and contain unnecessary costs.

Specifically, HCQCC recommends that EOHHS and its collaborators convene periodic educational forums that provide stakeholders with an opportunity to learn and share experience from other system redesign efforts. This will provide the health care community with an opportunity to learn and share experience from redesign efforts. The forums will provide an opportunity to showcase elements of the science of redesign, such as re-engineering patient flow and use of best practices, as well as infrastructure improvements that impact the day to day functioning of provider offices. The forums should present examples from within Massachusetts as well as other redesign successes across the country.

In addition to forums, EOHHS and its collaborators should work to support research projects focused on successful elements of system redesign, cross-industry partnerships to promote learning from successes in other businesses and improvement collaboratives.

Implementation Activities and Costs

An effort to support system redesign will require the following action steps:

1. EOHHS should invite and convene interested key community health care stakeholders, employers and universities.
2. The group should develop potential agenda topics and timeframes for a series of education al forums to support system redesign.
3. The group should identify grant or other funding to support this endeavor.
4. If funding is available, the group should also consider supporting research, cross-industry partnerships and improvement collaboratives.

Why is Support for System Redesign Necessary?

System redesign is paramount to improving the quality of care provided in the Commonwealth and containing the cost growth for that care. As noted earlier, a significant portion of health care

dollars is associated with overuse, misuse, and underuse of health care resources.[154] Often, this unnecessary use of health care resources is caused by duplication, system failures, poor communication, and inefficiency.

A collaborative effort of system redesign, and support of that effort, is necessary to meet the urgency of need to contain costs in the Commonwealth. Collective learning will be necessary for the successful implementation of other Roadmap strategies, particularly the adoption of comprehensive payment reform.

Barriers to Implementation

Despite the attention being paid to the need to contain costs, most health care providers and payers are struggling to meet their current resource needs to run their practices, plans, or programs. Given that, it may be difficult to engage the health care community as a whole as each organization struggles. In addition, in the current budget climate, there is little money available across the system to sponsor educational forums or other supporting projects. To address both of these issues, it will be paramount to work collaboratively with organizations to fund this endeavor and to make clear the benefits of participation.

Conclusion

While this strategy does not in and of itself contain health care costs, it is a key support function that will help other Roadmap strategies to succeed.

Promoting Transparency

As described in Chapter Four, there are significant efforts well underway in the Commonwealth that promote transparency of data and analysis on health care quality and costs.

HCQCC believes that while these current efforts are a good start with respect to transparency in the delivery system, there is still more to be done both through continued HCQCC efforts to add to its database and reporting capabilities. In addition, as a first step towards greater transparency in the payer system, HCQCC supports the Patrick administration's recently announced efforts to expand the Division of Insurance's (DOI's) current review of insurance premiums and to expand DOI's authority. DOI will soon be holding hearings to examine small business premium increases, focused on efforts of plans to reduce costs and future steps that may be needed to eliminate the substantial increases impacting the small group market. The Patrick administration also plans to file legislation that will amend small-group rating rules, giving DOI expanded power to annually eliminate unnecessary administrative costs and align factors in ways that could reduce the premiums charged to most small businesses. It also plans to file legislation that will expand DOI's authority over health insurance premiums to allow for prospective rate review and disapproval of rates deemed unreasonable in relation to the benefits provided. As DOI increases its review of health insurance premiums, HCQCC recommends that DOI develop standard measures of transparency to allow for true comparison across the plans.

[154] See, for example, Becher EC and Chassin MR. "Improving The Quality Of Health Care: Who Will Lead?" *Health Affair*s, 20(5), 164-179, 2001.

Potential for Reducing Health Care Costs

In reviewing potential strategies for the Roadmap that would allow HCQCC to reach its goal, HCQCC concluded that the Roadmap needs to provide tools to shift the spending curve by creating a more efficient health care base, while putting in place strategies to reduce the rate of cost growth over time. A Roadmap that only addresses short-term reductions in cost without addressing the underlying system design and payment incentive problems would not adequately address the Commonwealth's health care cost crisis.

Specifically, to reduce costs by $4 billion in the next three years would require dramatic and blunt action. It is HCQCC's belief that such action would require rate controls and freezes on providers and insurers. Utilizing rate controls requires statutory and regulatory changes; putting such authorization in place will take approximately 13 months to accomplish.[155] Once in place, it is likely that to reach the goal of reducing cost growth to GDP by 2012, the state may need to take action to not only freeze rates, but to actually reduce rates below their current levels. Implementing rate controls and freezes likely will distract energy and attention from efforts to redesign the health care system and create positive incentives for change over the long-term.[156] Moreover, implementing such rate freezes may have a dramatic impact on the ability of providers to operate and may drastically reduce health insurer reserves.[157]

Taken together, the eleven strategies included within this Roadmap will put the Commonwealth on course to meet our cost containment goals. RAND, in a study commissioned earlier this year by the Division of Health Care Finance and Policy, estimated spending on health care in Massachusetts in 2010 at $43 billion, and cumulative spending between 2010 and 2020 at $670 billion.[158] The strategies recommended in this Roadmap provide tools to shift the spending curve by creating a more efficient health care base, while also reducing the rate of cost growth over time.

As detailed in RAND's report analyzing potential strategies, it is difficult to precisely estimate health care cost savings.[159] There is limited empirical evidence or literature that provides solid evidence that the proposed cost containment strategies will, in fact, save dollars in the long run. In nearly half of the strategies that RAND undertook to review, RAND determined that they would not be able to accurately model any savings.[160]

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[155] This time frame estimates that it will take up to six months to draft, file and secure the passage of legislation to allow the state to regulate provider rates and premiums, four months to draft regulations, two months to propose regulations and a hold public hearing, and one month to adopt regulations following the hearing. Following an implementation of freezes on provider rates or premiums, the state would need to devote resources to monitoring the implementation of a freeze. The first set of data could be analyzed within six to nine months following the implementation of a freeze.

[156] Christine E. Eibner, Hussey PS, Ridgely MS, and McGlynn EA. "Controlling Health Care Spending in Massachusetts: An Analysis of Option," The RAND Corporation, August 2009.

[157] For more detailed information on the potential impact of premium or rate freezes, see Impact of Freezing Provider Payment Rates and Health Insurance Premiums, prepared by DHCFP at the Request of the Cost Containment Committee and presented at the September 8, 2009 Cost Containment Committee meeting.

[158] Christine E. Eibner, Hussey PS, Ridgely MS, and McGlynn EA. "Controlling Health Care Spending in Massachusetts: AnAnalysis of Options," The RAND Corporation, August 2009.

[159] Ibid, p. 4.

[160] Ibid, p. 39.

Of the eleven strategies ultimately included in the Roadmap, RAND modeled only two. In each of these cases, RAND modeled the potential savings without the inclusion of Medicare. We are advocating the inclusion of Medicare in cost control efforts, and therefore expect that potential savings could be much larger than RAND predicted. RAND's estimates include:

> **Health Information Technology Adoption**: RAND found that increased adoption of HIT had a savings range of a potential increase of $3.7 billion to a decrease of $12.1 billion over ten years.
>
> **Value-Based Insurance Design**: RAND found that implementation of value-based insurance design had a savings range of a potential increase of $1.1 billion to a decrease of $1.2 billion over ten years.

Independent estimates of the effect of global payments on health care spending are not available. There are almost no experimental or quasi-experimental studies with capitation in the United States,[161] let alone with more comprehensive notions of global payments. Where research has been performed using other methods, it generally has shown that risk-sharing with providers reduced utilization and costs relative to fee-for-service payment. Most of this research was performed studying the capitation arrangements in use in the late 1980s and early 1990s.[162] RAND modeled a number of cost control interventions that likely would occur as a result of payment reform. HCQCC believes that these strategies will be undertaken by providers in preparation for or as a result of payment reform and create a reasonable expectation that total savings will exceed the amount estimated for bundled payments. These include:

- Create medical homes to enhance primary care, with a savings range of a potential increase of $2.8 billion to a decrease of $5.7 billion over ten years.
- Encourage greater use of nurse practitioners and physician assistants, with a savings range of $4.2 billion to $8.4 billion over ten years.
- Eliminate payment for adverse hospital events, with a savings range of $7.6 billion to $12.3 billion over ten years.[163]
- Implement bundled payment strategies, with a savings potential between $685 million and $39 billion over the next ten years.[164]

As part of this Roadmap, HCQCC will monitor efforts to implement the recommended longer-term strategies as described in Chapter Seven. If those efforts are not appropriately progressing, HCQCC will consider modifying this Roadmap to include regulatory efforts to contain costs.

[161] Meredith Rosenthal, personal communication, July 10, 2009.
[162] Mathematica Policy Research. "Appendix C.2 Global Payment," from Recommendations of the Special Commission on the Health Care Payment System, July 16, 2009.
[163] Massachusetts payers and providers have already taken steps to reduce or eliminate payments for adverse hospital events.
[164] RAND, p. 13.

Chapter 6: Integrating and Implementing

The eleven Roadmap strategies, as noted above, may all be pursued independently and have an impact on containing health care cost growth and improving quality in the Commonwealth. However, HCQCC is of the firm belief that each of the strategies is stronger if implemented as part of an integrated package of cost containment strategies. Together the strategies present a strong commitment to a health care delivery system that is focused on improving the quality and efficiency of our health care simultaneously. Our collective ability to integrate the individual strategies will be an important piece of the successful implementation of each individual strategy.

The Roadmap recommends significant government action. Each strategy requires government intervention, either by government playing the role of convener, or by government enacting legislation to further the policy and cost containment goals described in the Roadmap. In addition to active involvement from government, the strategies also require input and shaping from all health care stakeholders, including consumers, employers, insurers, and providers. Without the participation and commitment to implementing these strategies by health care stakeholders, government will have limited ability to move them forward. In particular, government will require participation from consumers, employers, insurers, and providers to move forward efforts to utilize evidence-based coverage informed by cost effectiveness information. Similarly, efforts to develop health plan designs utilizing innovative strategies that promote use of high-value care will require the participation and commitment of consumers, employers, and insurers. Perhaps most importantly, our efforts to promote healthy behaviors require commitment and participation from all of us, individually and collectively.

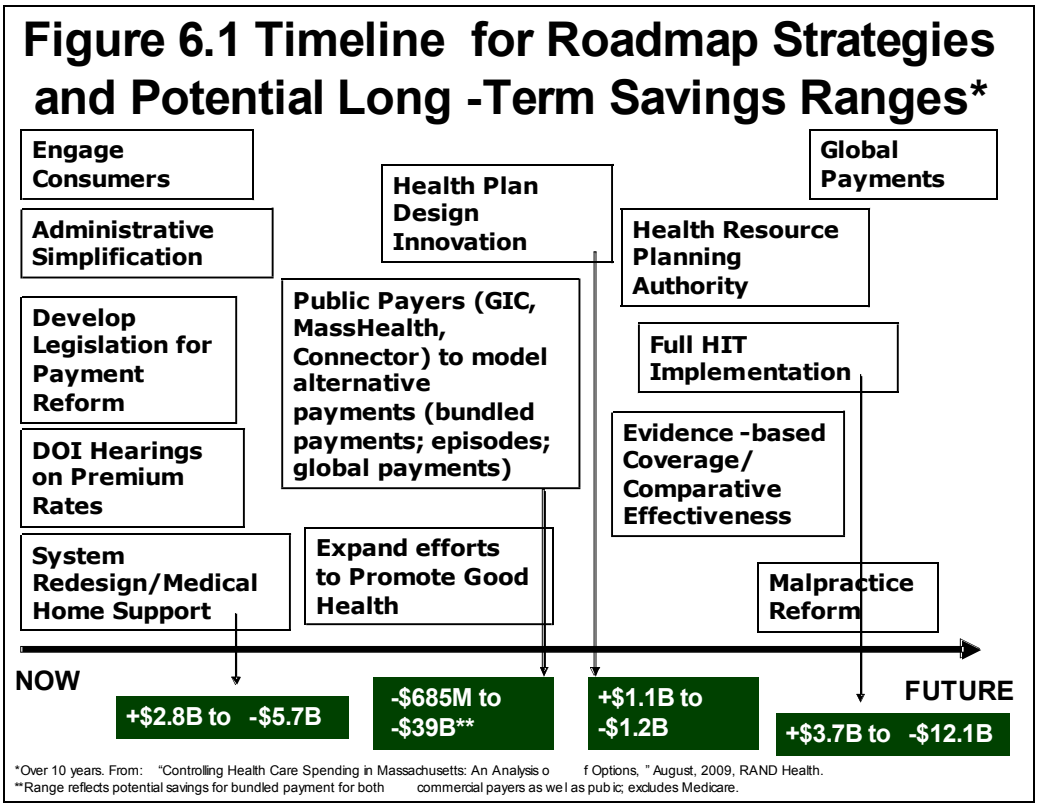
A number of strategies will provide us with the necessary infrastructure and protections to implement other strategies to the fullest. For example, adopting and utilizing HIT statewide will allow for easier adoption of comprehensive payment reform and easier adoption of evidence-based coverage strategies. When combined with malpractice reform and peer review protections, providers will have greater ability and incentive to reduce use of defensive medicine and to increase learning across provider systems. Health resource planning will give us the tools to expand our resources in services and areas where the Commonwealth has reduced capacity and to prevent expansion in services and areas where there is sufficient capacity. Table 6.1 below describes the expected impact of each of the strategies within the Roadmap and illustrates how the strategies are overlapping and reinforcing.

Table 6.1: Expected Impact of Roadmap Strategies

Strategy	Expected Impact
Adopt comprehensive payment reform	Shift to lower-cost providers and settings Reduction in provider-determined demand for low-value care Reduction in ER usage Reduction in hospital readmission rates Reduction in preventable hospitalizations Reduction in HAIs and SREs
Adopt and use health information technology (HIT)	Reduction in overuse, misuse and underuse of care Greater efficiency in care delivery processes Reduction in administrative costs
Implement evidence-based coverage	Reduction in overuse, misuse and underuse of care Less substitution of higher-cost for lower-cost technology if value is not proven
Develop health resource planning	Reduction in overuse of care Increased capacity in underserved geographic areas and underserved practice areas Reduced supply of low-value services Increased supply of high-value services
Implement health plan design innovation	Increased consumer engagement Increased consumer demand for high-value services, such as preventive services
Enact malpractice reform and peer review	Reduction in overuse, misuse and underuse of care Decrease in medical errors and unwarranted practice variation
Implement administrative simplification	Reduction in price of provider services Decreased share of payer spending on administration
Engage consumers	Reduction in demand for low-value care Reduction in ER usage Reduction in hospital readmission rates Reduction in preventable hospitalizations
Promote good health	Reduced incidence of obesity and related chronic diseases (long-term) Reduced incidence of smoking and related chronic diseases (long-term) Reduced demand for services associated with preventable illness

Support system redesign	Shift to lower-cost providers and settings Reduction in provider-determined demand for low-value care Reduction in ER usage Reduction in hospital readmission rates Reduction in preventable hospitalizations Reduction in HAIs and SREs
Increased transparency	Increased understanding of cost drivers in system

Figure 6.1 below provides a graphic depiction of the timeline anticipated to implement the strategies suggested in the Roadmap.



A detailed draft Roadmap implementation plan, including proposed timeframes and responsible parties, is included in Appendix C.

Chapter 7: Measuring, Monitoring, and Mid-Course Corrections

Since its inception, and as mandated by statute, HCQCC has focused much of its work on system monitoring and transparency. As part of this Roadmap, HCQCC reasserts the importance of its responsibility to monitor the health care system, aimed at two goals:

- Monitoring the overall performance of the health care system
- Comparing performance across provider systems, including,
    - Overall cost and quality
    - Comparative cost and quality analysis
    - Publication of data for use by consumers and employers

A Scorecard for Progress on the Roadmap

Specific to the Roadmap, HCQCC will undertake to monitor cost containment based on health care trends in the state, progress on implementing Roadmap implementation, and quality measures focused on areas that improve quality and reduce overall costs in the system. To that end, HCQCC will develop a scorecard that it will produce no less than annually, which shall include, at a minimum, aggregate measures of quality, cost, and efficiency such as:

- Coordinated, Integrated Care:
    - Reduction in emergency room usage
    - Reduction in hospital readmission rates
    - Reduction in preventable hospitalizations

- Hospital Safety
    - Reduction in hospital-acquired infections
    - Reduction in serious reportable events

- Patient-Centered Care
    - Patient experience: communication, coordination, how well your doctor knows you, and preventive care and activities

- Efficiency
    - Increase in amount of provider payments being made as global payments
    - Increase in provider rates of "meaningful use" of HIT

- Cost
    - Decrease in per capita health care spending
    - Decrease in annual growth in health insurance premiums

The measures should be compared over time, and should also be compared to best practice states or providers, either within Massachusetts or elsewhere in the country. In addition, HCQCC

encourages the development of more "patient-focused" measures which assess care across multiple settings and circumstances.

Most data necessary to report on the measures selected above are currently available through either HCQCC's or DHCFP's databases.

Implementation Activities and Cost Related to a Scorecard

The annual production of a scorecard measuring progress in HCQCC's Roadmap to Cost Containment will require the following implementation steps:

1. Finalize measurement topics to be included within scorecard
2. Select specific goals for the state in terms of percentage of improvement (whether based on a reduction, increase or decrease) with technical assistance
3. Utilize existing data sources to collect and report on measures[165]
4. Produce scorecard, at least annually, of aggregate data.
5. Post scorecard on HCQCC's website and issue brief report on progress towards HCQCC's cost containment goals.

Why Is a Scorecard Necessary?

As has previously been stated in this report, current health care spending is unsustainable. HCQCC must take an active role in monitoring the progress the Commonwealth is making in containing costs and improving quality. A scorecard will allow for a high-level view for policymakers as to the aggregate success of the complimentary cost containment strategies recommended within this Roadmap. It will serve as an indicator as to whether strategies are progressing as intended, or that there is a need for closer monitoring and potential course-correction for a particular strategy.

Barriers to producing a scorecard

As HCQCC has experienced in the development and production of its consumer-focused website, it is challenging to produce accurate and meaningful measures that are actionable. However, HCQCC is confident in its ability to leverage its previous experience with measurement and to, as available and appropriate, include within its scorecard relevant measures that are otherwise collected within the Commonwealth.

Conclusion

A scorecard reporting on the Commonwealth's progress in implementing strategies and reducing cost growth in health care towards HCQCC's goal of GDP is an important part of the overall Roadmap strategy. A scorecard, combined with HCQCC's ongoing efforts to monitor progress towards the implementation of the strategies within this Roadmap, will allow HCQCC to document the effects of our cost control efforts and provide a means for accountability for the Roadmap's implementation. Further, HCQCC's ongoing commitment to measuring and monitoring progress in our cost control efforts, and undertaking necessary mid-course corrections, will provide the Commonwealth with the means to measure the success of these

[165] Appendix D includes baseline data for suggested measures where the data is currently being collected; provided by the Division of Health Care Finance and Policy, October 15, 2009.

strategies, and specifically, to gain an understanding of which of the strategies is most successful in containing costs over time.

Additional Monitoring

In addition to producing a scorecard, HCQCC will receive periodic updates on progress in implementing each of the nine strategies included within the Roadmap. Specifically, HCQCC will request quarterly progress reports on each of the Roadmap strategies be submitted to the Cost Containment Committee.

Chapter 8: Conclusion and Next Steps

In order to maintain the gains that Massachusetts has made in health care coverage and ensuring that health care is affordable to individuals, employers and the Commonwealth, the state must take steps to reduce cost growth immediately. This Roadmap is HCQCC's recommendation to do just that. Timely implementation of these strategies will provide the Commonwealth with important tools to contain costs.

As detailed in the Roadmap Implementation Plan, included as Appendix C, there is much work to be done. The Roadmap calls for the government through the state legislature and the Patrick administration to enact legislation to allow for implementation of many of these strategies, in addition to convening groups to kick-off strategies whether or not legislation is required. Further, the Roadmap urges continuation of a number of strategies underway for state agencies, including efforts at administrative simplification and DPH's efforts to promote good health. Other stakeholders are also needed to do their parts. Employers and consumers are tasked with taking a greater role in developing insurance products that incentivize good care and to take a greater role in treatment. Insurers and providers are tasked with changing the way they currently do business to focus on payment strategies that incentivize quality care instead of more care, and to increase efforts to provide evidence-based care.

While payment reform is likely to have the biggest overall impact on containing costs in the system, it is not as likely to succeed on its own. Implementing the Roadmap's integrated strategies will reinforce the benefits of each of the individual strategies. HCQCC urges quick action by the state legislature and Patrick administration on the strategies delineated in this report.

For its part, HCQCC will continue to focus its efforts on monitoring cost and quality within Massachusetts' health care, with an eye towards monitoring progress on implementation of the Roadmap.

Appendix A: RAND's Strategy List Considered by Cost Containment Committee

Reform Payment Systems

- Institute hospital all-payer rate setting
- Utilize bundled payment strategies
- Increase use of pay-for-performance
- Regulate insurance premiums
- Increase Medicaid reimbursement
- Pay academic medical centers (AMCs) a community rate
- Use reference pricing for AMCs

Redesign the Health care Delivery System

- Promote the growth of retail clinics
- Create medical homes
- Change scope of practice and payment policies for NPs and PAs
- Increase the use of preventive care
- Increase the use of disease management

Reduce Waste

- Reduce administrative overhead
- Extend the Determination of Need (DoN) process
- Increase the adoption of HIT
- Use comparative effective analysis to guide coverage and payment rules
- Eliminate payment for preventable readmissions and hospital-acquired infections
- Decrease intensity of resource use for end-of-life care

Encourage Consumers to Make Good Health Choices

- Encourage value-based insurance design
- Promote wellness/healthy behaviors

Change Medical Liability Laws

Change laws related to the non-economic damages cap and expert witnesses

Appendix B: Principles and Criteria for the Roadmap

How the HCQCC Does Its Work
HCQCC should:

- recognize that change to the status quo is a likely outcome;
- be honest about who will be impacted by the cost containment strategies, and how, and give attention to both winners and losers;
- recommend a balance of short, mid and long-term initiatives, and
- be transparent in its design and implementation of cost containment strategies.

The Selected Strategies
Cost containment strategies should:

- possess clear and documented savings potential;
- focus delivery system attention on patient outcomes, efficient care delivery, and minimization of low-value services;
- maintain or improve quality, access and disparities;
- give attention to both health care market issues and to public health;
- focus across the health care system and be complementary;
- return a portion of the savings to those whose efforts have generated them;
- strive for simplicity to the extent possible;
- be designed such that it is clear when, how and by whom they are to be implemented, and what, if any, action should be taken by state government to support the effort, and
- be designed with plans for evaluation for unintended consequences and for mid-course corrections, as necessary.

Recommended cost containment strategies should address HCQCC's principles for cost containment and:

- possess a high probability of achieving HCQCC's goal of reducing health care cost growth in Massachusetts to the growth rate of the GDP;
- be subject to the influence of government action;
- require a shared effort by the health care delivery system, insurers, employers, consumers and state government;
- have the support of key constituents who will need to be party to the change process, and
- be feasible to implement, both administratively and politically.

Appendix C: Draft Roadmap Implementation Plan

Roadmap to Cost Containment: Draft Implementation Plan				
	Strategy	**Task**	**Responsible Party**	**Expected Time Frame**
1	Payment Reform	Draft and submit legislation to implement recommendations of the Special Commission, with input from the HCQCC	Administration/ Legislature	Fall 2009
2	HIT	Adopt statewide HIT plan	HIT Council	Fall 2009
3	Evidence Based Coverage	Convene payers, consumers, employers, and clinical experts to discuss formation of evidence-based coverage forum	DHCFP/DOI	Fall 2009
4	Health Resource Planning	Submit Legislation to enhance EOHHS's health resource planning authority	EOHHS	Fall 2009
5	Health Plan Design Innovation	Convene standing committee charged with developing and promoting Value-Based Insurance Products (Committee to meet monthly)	DOI	Fall 2009
6	Malpractice Reform and Peer Review	Consider pending malpractice legislation; enact reform or determine need to create a commission on craft a new bill	Legislature	Fall 2009
6	Malpractice Reform and Peer Review	Consider pending peer review legislation that would expand peer review protection	Legislature	Fall 2009
8	Engage Consumers	Include consumer engagement as part of EOHHS multi-payer, patient-centered medical home initiative	EOHHS	Fall 2009
9	Encourage Healthy Behaviors	Develop plan to expand Mass in Motion to include additional MA communities	DPH	Fall 2009
12	Scorecard	Develop scorecard to monitor progress of roadmap to cost containment with	HCQCC	Fall 2009

Roadmap to Cost Containment: Draft Implementation Plan				
	Strategy	**Task**	**Responsible Party**	**Expected Time Frame**
		existing, available measures		
7	Administrative Simplification	Continue efforts to develop uniform billing standards	DOI	ongoing
7	Administrative Simplification	Continue efforts to reduce duplication in reporting across EOHHS and other state government entities	EOHHS	ongoing
1	Payment Reform	Monitoring of progress in moving to global payments and impact on health care system	HCQCC	Quarterly (beginning Fall 2010)
9	Encourage Healthy Behaviors	Request funding from Legislature or private funders to expand Mass in Motion grants	DPH	Winter 2010
9	Encourage Healthy Behaviors	Continue and expand work with employers to increase work place wellness programs	DPH	Winter 2010
9	Encourage Healthy Behaviors	Continue to implement evidence-based interventions through the Public Health Council, such as nutritional labeling in school and BMI measurement	DPH	Winter 2010
10	Health System Redesign support	Convene coordinating committee to plan educational forums and other support	EOHHS	Winter 2010
12	Scorecard	Identify additional measures that would like to include in scorecard	HCQCC	Winter 2010
3	Evidence Based Coverage	Create a non-profit entity to serve as forum for adopting evidence-based coverage strategy	Payers	Winter/Spring 2010
4	Health Resource Planning	Enact Legislation and appropriate funding	Legislature	Winter/Spring 2010
12	Scorecard	Develop plan to allow for reporting of additional measures	HCQCC	Winter/Spring 2010

Roadmap to Cost Containment: Draft Implementation Plan				
	Strategy	**Task**	**Responsible Party**	**Expected Time Frame**
1	Payment Reform	Monitor payment reform strategies for increased use of pay-for-performance; bundled or episode-based payments; medical home support; reduced payment for HAI and preventable readmissions	DHCFP/HCQCC	Quarterly (beginning Winter 2010)
2	HIT	Monitor progress towards adoption of HIT by providers statewide	HCQCC	Quarterly (beginning Winter 2010)
3	Evidence Based Coverage	Monitor progress towards implementing strategy	HCQCC	Quarterly (beginning Winter 2010)
4	Health Resource Planning	Monitor progress towards implementing strategy	HCQCC	Quarterly (beginning Winter 2010)
5	Health Plan Design Innovation	Monitor progress towards implementing strategy	HCQCC	Quarterly (beginning Winter 2010)
6	Malpractice Reform and Peer Review	Monitor progress towards implementing strategy	HCQCC	Quarterly (beginning Winter 2010)
7	Administrative Simplification	Monitor state and private efforts to reduce administrative complexity	HCQCC	Quarterly (beginning Winter 2010)
8	Engage Consumers	Monitor ongoing efforts and impact of Partnership for HealthCare Excellence	HCQCC	Quarterly (beginning Winter 2010)
8	Engage Consumers	Monitor efforts to include consumer engagement within statewide medical home work	HCQCC	Quarterly (beginning Winter 2010)
9	Encourage Healthy Behaviors	Monitor progress towards expanding these efforts	HCQCC	Quarterly (beginning Winter 2010)
11	Promote Transparency	Monitor efforts by DHCFP, DOI, AG to gather and make public information on current health care spending, premium trends, and other information.	HCQCC	Quarterly (beginning Winter 2010)

Roadmap to Cost Containment: Draft Implementation Plan				
	Strategy	**Task**	**Responsible Party**	**Expected Time Frame**
1	Payment Reform	Hold hearings and enact payment reform; appropriate necessary funding	Legislature	Spring 2010
11	Promote Transparency	Expand DOI authority to hold premium hearings and/or approve of rates of individual products	Legislature	Spring 2010
4	Health Resource Planning	Staff health resource planning activities	EOHHS	Summer 2010
12	Scorecard	Publish scorecard on annual basis	HCQCC	Summer 2010 (and annually thereafter)
1	Payment Reform	Utilize Board, as recommended in Special Commission report or other entity, to help build capacity and provide technical assistance to utilize global payments	TBD	Summer 2010 and ongoing

Appendix D: Baseline Data for Select Suggested Measures

Proposed Roadmap to Cost Containment Scorecard Measures			
Measure	**Data Source**	**Frequency**	**Baseline**
Reduction in ED Usage			
a) Outpatient ED visits by MA residents	DHCFP ED Database	Annual	2.2 million (FY2006)
b) Percentage of outpatient ED visits that are considered preventable/avoidable (MA residents)	DHCFP ED Database	Annual	47% (FY2006)*
Reduction in Hospital Readmission Rates			
a) 30-day Potentially Preventable Readmission (PPR) Rate	DHCFP HDD Database and 3M PPR Algorithm	Annual	10.7% (FY2006)
b) Medicare 30-day hospital readmissions as a percent of all admissions	Commonwealth Fund State Scorecard	Annual	19.4% (2006/2007)
Reduction in Preventable Hospitalizations			
a) Percentage of estimated inpatient hospitalization costs spent on preventable admissions	DHCFP HDD Database and AHRQ PQI Methodology	Annual	8% (FY2006)
Reduction in Hospital Acquired Infections			
a) Number of MA hospital reported central bloodstream infections	Hospital reporting to CDC as required under DPH licensure regulations	Annual	Expect results to be available 4/10 for FY2009
b) Number of MA hospital reported surgical site infections	Hospital reporting to CDC as required under DPH licensure regulations	Annual	Expect results to be available 4/10 for FY2009
Reduction in Serious Reportable Events			
a) Total count of serious reportable events from all hospitals	Hospital reporting to DPH	Annual	338 (CY2008)
b) Rate of serious reportable events per 100,000 patient days	Hospital reporting to DPH	Annual	8.3 (CY2008)
Increase in Prevalence of Global Payments			

Proposed Roadmap to Cost Containment Scorecard Measures			
Measure	**Data Source**	**Frequency**	**Baseline**
a) Percentage of total payments made under global payment arrangement	DHCFP annual survey of carriers	Annual	20%**
Increase in provider rates of meaningful use of HIT			
	TBD - eHealth Collaborative?		Pending
Increase in consumer engagement			
	TBD		Pending
Increase in use of hospice and home health care			
a) Number of MA hospice patients; % of MA deaths cared for in hospice	Hospice and Palliative Care Federation of MA	Annual	21,258 (2007); 40% of MA deaths (2007)
b) % of end-of-life patients who received palliative care ordered by physicians	DHCFP HDD Data	Annual	10.6% (2007)***
c) % of MA deaths at home; % of MA deaths at hospice/other	DPH	Annual	24% of deaths at home (2007); 3% of deaths in hospice
d) # persons per 1,000 Medicare enrollees getting home health care; # of home health visits per 1,000 Medicare enrollees	CMS Medicare Data	Annual	113 persons per 1,000 enrollees (2006); 3,790 visits per 1,000 enrollees (2006)
Decrease in per capita health care spending			
a) Health care expenditures per capita	CMS SHEA Data	Every 5 years	$6,683 (2004)
b) Projected Health care expenditures	DHCFP projection of CMS estimate	Projection	$8,895 (2008)
c) PM/PM Health care expenditures	DHCFP Cost Trends Data	Annual	pending (2008)
Decrease in annual growth in health insurance premiums			
a) Single and family annual premium	MEPS-IC	Annual	$4,836 Single (2008) $13,788 Family(2008)
b) Per member/per month premium (adjusted for benefits and demographics)	DHCFP Cost Trends Data	Annual	Pending (2008)

*This percentage may change somewhat with an update of Billings Algorithm
**Estimate by Bailit for commercial physician payments - reported in recommendations of the Special Commission on Payment Reform
*** End-of-life patients include adults only and include some trauma deaths. Future analysis will exclude deaths due to traumatic injury, so percentage is likely to increase somewhat.

Attachment A: Services Reviewed by the Minnesota Health Services Advisory Council, 2006-2009[166]

TOPIC AREA	ACTION TAKEN
Arthroscopic Knee Surgery for Osteoarthritis	Evidence-based prior authorization (PA) criteria developed, procedures placed on PA.
Bariatric Surgery	Evidence-based update of the PA criteria, drafting of separate criteria for the under-18 population.
BRCA Genetic Mutation Testing for Breast and Ovarian Cancer Susceptibility	Evidence-based PA criteria developed, procedures placed on PA.
Breast MRI	Evidence-based PA criteria developed, procedures placed on PA.
Cardiac MRI	Evidence-based PA criteria developed, procedures placed on PA.
Coronary CT Angiography	Evidence-based PA criteria developed, procedures placed on PA.
High Tech Imaging for Cervical Spine Pain	Evidence-based PA criteria developed.
High Tech Imaging for Dementia	Evidence-based PA criteria developed.
High Tech Imaging for Headache	Evidence-based PA criteria developed.
High Tech Imaging for Knee Pain	Evidence-based PA criteria developed.
High Tech Imaging for Low Back Pain	Evidence-based PA criteria developed.
High Tech Imaging for Shoulder Pain	Evidence-based PA criteria developed.
Home Uterine Activity Monitoring	Evidence reviewed, DHS and HSAC elected to maintain the existing PA criteria.
Percutaneous Coronary Intervention (PCI) for Patients with Stable Angina	IN PROGRESS
Radiofrequency Neuroablation for Chronic Low Back Pain	Evidence-based PA criteria developed, procedures placed on PA.
Screening Ultrasound for Uncomplicated Pregnancy	Evidence-based coverage criteria proposed and implemented.
Sleep Testing for Adults	Evidence-based coverage criteria proposed and implemented.
Spinal Cord Stimulation for Chronic Pain	Evidence-based PA criteria developed, procedures placed on PA.
Spinal Fusion Surgery	Evidence-based update of the PA criteria.
Surgical Treatment of Gastroesophageal Reflux Disease (GERD)	Evidence-based PA criteria developed, procedures placed on PA.
Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain	Evidence-based PA criteria developed, procedures placed on PA.
Virtual Colonoscopy/CT Colonography	Evidence-based PA criteria developed, procedures placed on PA.

[166] As of August 7, 2009. Personal communication with Dr. Jeffrey Schiff, Minnesota Department of Human Services, August 7, 2009.

Copies of this report are available from the Health Care Quality and Cost Council.

The report is available online at http://www.mass.gov/healthcare.

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